A critical review of the literature on children and young people's views of the factors that influence their mental health

September 2009

Janet Shucksmith, University of Teesside
Jenny Spratt, University of Aberdeen
Kate Philip, University of Aberdeen
Rebekah McNaughton, University of Teesside

Published by NHS Health Scotland,
Woodburn House, Canaan Lane, Edinburgh, EH10 4SG
© NHS Health Scotland 2008

NHS Health Scotland

The opinions expressed in this publication are those of the authors and do not necessarily reflect those of NHS Health Scotland.

Contents

Acknowledgements i

Summary ii

1 Introduction 1

1.1 The context 1
1.2 Developing a set of indicators 5
1.3 What is meant by mental health? 7
1.4 Existing work on children and young people's views of mental health 8
1.5 Structure of this report 9

2 Aims and Objectives 10

3 Methods 11

3.1 Phase one 11
3.1.1 Establishing search strings and searching for peer-reviewed literature 11
3.1.2 Screening abstracts for relevance and inclusion 13
3.1.3 Quality assessment of peer-reviewed literature 14
3.1.4 Data extraction of peer-reviewed literature 15
3.1.5 Searching for 'grey' literature 15
3.1.6 Screening of 'grey' literature for relevance and inclusion 16
3.1.7 Quality assessment of 'grey' literature 16
3.1.8 Data extraction of 'grey' literature 16
3.2 Phase 2 18
3.2.1 Approach taken to synthesis of the literature 18
3.3 Methodological approaches of the papers reviewed 18
3.3.1 Different populations of young people 19
3.3.2 Diversity within samples 19

4 Results 20

4.1 Children and young people's understanding of mental wellbeing 20
4.2 Children and young people's understanding of mental health problems 22
4.3 Self: factors about themselves having an impact on children and young people's mental health 25
4.3.1 Positive factors about themselves having an impact on children and young people's mental health 25
4.3.2 Negative factors about themselves having an impact on children and young people's mental health 28
4.4 The pivotal role of family relationships on children and young people's mental health 30
4.4.1 Positive impacts of family on mental health 30

4.4.2 Negative impacts of family on mental health ... 34
4.5 The impact of school and peer relationships on children and young people's mental health ... 38
4.5.1 Positive impacts of school and peer relationships on mental health ... 38
4.5.2 Negative impacts of school and peer relationships on mental health ... 40
4.6 The pivotal role of friendships on children and young people's mental health ... 44
4.6.1 Positive impacts of friendships on children and young people's mental health ... 44
4.6.2 Negative impacts of friendships on children and young people's mental health ... 46
4.7 The role of relationships with other adults on children and young people's mental health ... 48
4.7.1 Positive impact of relationships with other adults on children and young people's mental health ... 48
4.7.2 Negative impact of relationships with other adults on children and young people's mental health ... 50
4.8 The impact of neighbourhoods and communities on children and young people's mental health ... 52
4.8.1 Ways in which neighbourhoods and communities impact positively on children and young people's mental health ... 52
4.8.2 Ways in which neighbourhoods and communities impact negatively on children and young people's mental health ... 53
4.9 The impact of structural factors on children and young people's mental health ... 54
4.9.1 Positive impact of structural factors on children and young people's mental health ... 54
4.9.2 Negative impact of structural factors on children and young people's mental health ... 55

5 Discussion ... 58
5.1 Children and young people's holistic view of mental health ... 58
5.2 Transitions ... 59
5.3 Having some control ... 60
5.4 Coping strategies ... 60
5.5 Limitations of this review ... 61
5.6 Harden – ten years on? ... 62
5.7 Implications of the findings for the mental health indicators framework ... 63

6 References ... 73

Appendices ... 79
Appendix 1: Search strategies ... 80
Appendix 2: Inclusion/exclusion criteria tool ... 86

Appendix 3: Quality assessment tool 88
Appendix 4: Data extraction tool 90
Appendix 5: List of sites searched for ‘grey’ literature 93
Appendix 6a: Evidence tables – peer-reviewed 94
Appendix 6b: Evidence tables – ‘grey’ 119

Acknowledgements

The research team would like to acknowledge the help of a number of people. The project steering group of Jane Parkinson (lead commissioner), Joanna Teuton and Anne Lee from NHS Health Scotland provided advice and support throughout the project in a thorough and timely way and provided comments on the report.

We are also indebted to a number of staff at the University of Teesside, namely Debbie Hall, Claire Athey, Lawrence Nnyanzi, and Tamara Brown who provided invaluable backup at critical points.

People who responded through the various UK networks and organisations that have an interest in children and young people's mental health and sent materials for our consideration also deserve our sincere thanks.

Summary

Introduction

This study was commissioned in order to examine what children and young people themselves perceive to be important in affecting their mental health for good or ill and was undertaken in the form of a systematic review of both published peer-reviewed and 'grey' literature.

The review forms part of a wider piece of work being undertaken in Scotland to develop a set of mental health indicators. To provide a means of assessing the mental health of Scotland's population and its context, NHS Health Scotland was commissioned by the Scottish Government to establish a set of national mental health indicators that could be used to create a summary mental health profile for Scotland. In NHS Health Scotland 'mental health' is used as an umbrella term to refer to both the concepts of mental health problems and mental wellbeing.

A set of indicators for adults was finalised in December 2007. NHS Health Scotland has now initiated work to establish a similar set of mental health indicators for children and young people in Scotland. This programme of work will be completed by April 2011 and the indicators will be developed at a national level, will be relevant to children and young people aged under 18 and will be relevant to the general population of children and young people.

It is important that the views of children and young people are included in development of the indicators. Some literature exists on what children and young people view as factors that influence their mental health which can be used as a basis to inform the indicators work. This had been reviewed by Harden *et al.* up to 1999. NHS Health Scotland therefore commissioned research in November 2008 to critically review the literature since 1999. The literature review will be just one method employed to inform the development of the framework for the mental health indicators and the indicators themselves. Decisions on the framework and indicators will also be informed by consultation with children and young people, discussions with an advisory group, by the availability of national data, the evidence-base, the policy context and by wider consultation with researchers, practitioners and policy makers.

Method

The review was carried out in two phases. Phase one included scoping, searching and screening for relevance and quality of the published and 'grey' literature whilst phase two focused on the synthesis of evidence. The first task was to establish the search string which would be used to conduct a systematic search of published peer-reviewed literature. This consisted of three main components with search terms centring on: children and young people; mental health (mental health problems and mental wellbeing); and views and opinions. The search string primarily used subject headings for each database supplemented with additional keyword searches of the title and abstract as

necessary. Searching was restricted to covering generic terms for mental health and very common terms for 'types' of mental health problems, such as depression, and anxiety and 'aspects' of mental wellbeing such as life satisfaction and self-esteem.

In total six databases (The Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), International Bibliography of the Social Sciences (IBSS), MEDLINE, psycINFO, and the Social Sciences Citation Index (SSCI)) were used to conduct the final search returning 11,549 results. The titles and abstracts were read and a set of primary inclusion criteria applied. These consisted of:

- a relevance criterion (must be reporting children and young people's **own** understanding of mental health or **own** understanding of factors that contribute to or are detrimental to their mental health
- a language criterion (must be written in English)
- a publication criterion (must be published in a peer-reviewed journal)
- a research style criterion (must be primary research, i.e. not reviews or theoretical argument)
- an age criterion (must deal with or represent views of children and young people between the ages of 0 and 18)
- a context criterion (must be undertaken in developed country (HDI>0.8))
- a publication span criterion (must be study published between 1999 and the end of 2008).

All abstracts which did not meet the inclusion criteria at this stage were discarded. In total 32 peer-reviewed papers were taken through to the quality assessment stage of the review. All were reviewed by a 'primary reviewer' and a selection of papers was reviewed by two additional reviewers. Each paper was read and scored against a set of quality criteria using a quality assessment tool adapted from the NICE framework. All 32 papers were rated overall as either high (++) or medium (+) quality and progressed to the next stage of review, data extraction. No papers were rejected on the basis of being classed as low quality (-). Each retained article was subjected to 'data extraction' using a tool based on those developed at the EPPI Centre.

To identify the 'grey' literature, a web-based search was carried out to find any research which had been conducted by agencies from across the United Kingdom which were known to have an interest in children and young people's mental health. Furthermore, these agencies were contacted via email to see if they had other publications which were relevant to the review which were not cited on their websites, or if they knew of any research carried out by people in their networks. There was a good response to this approach. In addition the research team and steering group used their own professional and academic networks to seek out unpublished literature of relevance to the review. The work was also publicised to practitioners at a Scottish Pupil Inclusion Network (PIN)

seminar and an email went out to all members in the network to forward to other relevant agencies and networks. Eighty-two pieces of 'grey' literature were identified through the searching process.

The 'grey' literature which met the inclusion criteria (8 reports) was subjected to the same quality sift as was used for the published peer-reviewed literature. Five reports were rated as either high (++) or medium (+) quality and progressed to data extraction.

Following the sifting process of quality assessment, researchers read all the papers, and independently identified key themes for the synthesis of the literature.

Results

Children and young people's understanding of mental wellbeing

Children and young people view mental health as comprised of both positive and negative factors. They relate mental wellbeing to internal feelings about the self and others, and to relational issues such as interactions with family, friends and others, as well as to external experiences and life events. Young people also report subjective wellbeing as 'fluid'. Their definitions focused on themes of being happy, and feeling good about themselves. Age is clearly critical when asking children and young people about abstract concepts. Young people in their mid teens offered clearer views on mental wellbeing. Younger children are less clear about what is meant by terms such as mental wellbeing.

Having energy, well balanced emotions, being able to interact positively, and being in harmony at school and in other places are reported as demonstrating mental wellbeing. Being good towards others was also seen as important to feeling good about yourself and being a 'self-confident person' was associated with mental wellbeing.

Children and young people's understanding of mental health problems

Children and young people found it easier to define poor mental health or mental health problems. As with mental wellbeing, poor mental health was felt to be a consequence of a wide range of environmental and individual factors. They described mental health problems as an accumulation of overlapping symptoms and signs. Mental health problems were described by them as consisting of feelings of unhappiness, anxiety and depression. Once in this condition, a sense of listlessness and heaviness was overwhelming. Tiredness was characteristic. The onset of mental health problems was seen in part as deviation from the 'norm'.

Those young people already diagnosed with some form of mental health problem often expressed clear understanding of the nature of their conditions and offered coherent accounts of symptoms and treatment.

Thus, for instance, children and young people with depression reported that being diagnosed with a mental health problem allowed access to services but brought with it a stigma which increased their vulnerability and was likely to stay with them and influence their life opportunities. Similarly, young people with an attention deficit hyperactivity disorder (ADHD) diagnosis reported that the condition became a major part of their identity, defining them as 'not normal'. However, medication also made them feel as if they were no longer their true selves

Factors about themselves having an impact on children and young people's mental health

Aspects of the self which contributed to mental wellbeing were identified as related to feeling healthy, positive and happy. Body image and appearance were important, especially to young women. Children and young people noted frequently that a sense of personal achievement was critical. For many this related to school success, but for boys, success was often achieved through sport. Some young people noted that the power of achievement in making them feel good and contributing to mental wellbeing was the recognition and regard it brought from others, particularly parents. Having some control over and understanding of their emotions was important for some young people, but a sense of control over their own choices was important more generally in a number of studies.

Conversely, feeling bad about body image and physical maturation were identified by some young people as an aspect of the self that contributes to mental health problems, some of this being identified as arising from the pressures inherent in modern society's image of what young women in particular should look like. Aspects of gender stereotypes in relation to expected behaviour from girls are identified in one study as the root cause of a great deal of anger in young women associated with mental health problems. The need to 'grow up too soon' is identified as an additional problem by young women in one study.

Poor physical health experienced by young people with acute or chronic diseases is also associated with poor mental health. Worries and concerns about their health and the potential outcomes are exacerbated by the fact that health problems render them abnormal in this age group and the lack of normality, creating mental anguish, is almost as hard to bear as the original illness. The stress of being abnormal or having an abnormal 'childhood career' was also experienced by children and young people who had to act as carers or who were in care themselves. Young people with diagnosed mental health problems experienced stigmatisation as a further assault on their mental wellbeing and felt that it sometimes took over their identity.

The pivotal role of family relationships

It is clear from children and young people's accounts that relationships within the family can impact both positively and negatively on mental health. Age is

significant in determining the comparative importance of family versus peers/friends to young people, but remarkable consistency was evident in reports by children and young people about the importance of family relationships in creating and sustaining feelings of mental wellbeing.

The positive aspects of family relationships specifically identified by young people as important are: having a comfortable home, experiencing loving and trusting family relationships, having open communication, having strong familial involvement, but also having external relations (life outside the family). They also felt that the family gave a sense of safety and security. Many talked of being able to use the family as a form of support and 'buffering' against adversity, and being able to use the family to give support in decision-making. In the best circumstances families allowed children and young people to talk openly about difficulties and gave unconditional support in the case of health difficulties.

However, family discord was one of the most frequently mentioned causes of mental health problems by young people in a number of studies. Divorce and relationship breakdown was cited many times by young people as a source of mental health problems. Parents who were under stress themselves created further stresses for their children. Children often tried to help parents relieve their stress but felt ill equipped for the task.

Children of parents with a psychiatric disorder reported the way in which concern for parents and the need to adapt their own behaviour to their parent's erratic moods (and also to become carers in some cases) added considerably to their own mental health problems. Caring responsibilities for other family members were generally seen by young people as having a detrimental effect on their mental health, making them feel isolated and different from peers, and involving them in constant worry and loss of self-identity.

Children and young people in a number of studies mention loss or bereavement involving a family member as a source of mental health problems. Abusive relationships with parents (of both an emotional and physical kind) were said to precipitate mental health problems for some children and young people.

The impact of school and peer relationships

School was often not mentioned in general accounts by children and young people about mental health. School environment was mentioned in one study with children and young people expressing a preference for well maintained buildings which allowed places for young people to meet and talk, which could influence mental health according to them. Where school was mentioned, it was generally <u>relationships</u> at school, both positive and negative, which were the main focus of accounts. Friendships with peers are seen as one of the most important aspects of school which contributes to mental wellbeing. Relationships with teachers are also noted as important, the best being where teachers are respectful, kind and patient. Individualised support from teachers when facing

difficulties was seen as critically important in promoting mental wellbeing by those facing specific problems.

On the other side of the coin, poor school environments were said by young people in one study to affect the way they felt about school, with schools being likened to prisons and cages. A number of studies commented on how stress related to pressures of schoolwork affects many children and young people. These pressures related both to the pressure to succeed, but also the pressure to fit everything into an increasingly busy schedule.

Whereas good relationships with peers and teachers were identified by many as a positive factor, poor relationships with peers at school were a source of mental health problems identified by children and young people, particularly where bullying or gossip was involved. Poor relationships with teachers were equally problematic, and lack of understanding and failure to be offered specific supports by teachers when facing difficulties outside of the 'norm' such as chronic illness also caused problems severe enough to cause school withdrawal.

The pivotal role of friendships

A recurring theme was the importance of friendships to mental wellbeing. Important features of friendship included trustworthiness, being able to talk and be listened to, being able to share problems. Children and young people repeatedly identified the positive impact that the support of good friends could have through difficult times. For troubled adolescents, fending off depression involved coping strategies based on talking to reliable, knowledgeable and trusted friends.

On the other hand, the withdrawal of friendship through 'falling out' and argument was described as traumatic by young people. Rejection by or isolation from peers was seen as directly affecting children and young people's mental health. Mental health problems experienced by children and young people could in themselves cause estrangement from friends. Similar estrangement from friends and peers was experienced by other young people who fell outside the norm as a consequence of their own physical health problems or the health problems of parents where children had a caring role. Looked after children and young people who moved into and out of care or between placements found it equally difficult to sustain friendships, and they and young carers felt that their specific life experiences estranged them from friends who did not understand what they endured.

The role of relationships with other adults

Adults outside the family were rarely referred to by children and young people as sources of mental wellbeing support except professionals that they were in contact with (teachers, social workers etc). Children and young people described the value of having 'someone to talk to', but noted that choosing the right adult in whom to confide involved judgement on their part. Relationships with other

adults were described as having most value when adults were respectful, non-judgemental, trustworthy and sincere in their interactions. Where troubled children were in receipt of services they valued adults who treated them holistically and expressed faith in them and a desire to see treatment through to the end. Support from adults who had 'been there themselves' was seen as particularly important by looked after children. Young people saw as important their freedom to choose whether to participate in counselling or therapeutic support, and when (or whether) to disclose information.

Relationships with other adults were fraught with difficulties over the extent to which disclosures could be treated as confidential by adults. Access to therapeutic adult professionals was felt to be very necessary by some young people, but was often felt to be stigmatising. In addition, young people often did not know how to access services or felt that they would only be referred or receive treatment and support when problems had escalated to a very serious level. Working with adults outside the family was not seen by children and young people as beneficial when those people were overly controlling, dismissive of children and young people's accounts, blaming and over-keen to medicate.

Young people in care found it difficult to form relationships with other adults working with them because of constant staff turnover and patterns of shift working.

The impact of neighbourhoods and communities

Community settings that offered plenty of activities for children and young people were seen as promoting mental wellbeing. Sport was particularly mentioned as promoting feelings of happiness. One study highlighted the importance for mental wellbeing of activities that allowed young people to be of service to others.

Unpressured space for young people to meet and interact was seen as essential by young people. One study suggested that girls and young women needed single sex environments in which to do this as well as mixed ones.

Conversely, community settings that offered few opportunities for activities were seen as encouraging boredom that was itself seen as bad for mental wellbeing. Young people living in rural areas and areas of deprivation were most likely to cite the lack of activities in their area as bad for their mental health.

Young people living in communities where drugs are in widespread use noted these as being potentially injurious to their mental health. Violence in some communities was suggested in one study as a negative factor for mental health.

The impact of structural factors

In most instances children and young people do not refer directly in their own words to structural issues such as poverty, race and gender as lying behind

some of the more immediate and personal issues that beset them and impact on their mental health. Only young people living outwith the support of their family are more likely to evidence such factors as being critical to mental health. Appropriate support from service agencies delivering good housing for example was acknowledged by young people in one study as contributing to their mental wellbeing

Young people caring for parents with a mental health problem appeared to be the most acutely aware of the extent to which structural factors like poverty created the stressors that exacerbated their parent's condition.
Only one study specifically mentions young people's understandings of ethnicity/racial discrimination as a factor undermining mental health. Young people acknowledge that boys and girls vent their frustrations and express themselves differently; with girls often feeling obliged to suppress negative expressions of emotion because of gender stereotypes. Girls also saw themselves as under double pressure to conform to idealised views of what women should look like and how they should behave.

Discussion

Children and young people generally took a holistic approach to mental health, stressing the ways in which different aspects of their lives worked together to influence it. Individual stressors and day to day anxieties were viewed as part and parcel of growing up and young people generally felt that, given adequate support, they could deal with these. The converse was equally evident: social isolation, combined with difficult interaction with peers, family and teachers could trigger negative feelings and in turn could exacerbate feelings of poor self-worth and fitting in. It was the accumulation of stressors, rather than single factors, which young people described as being injurious to mental health.

There was a consensus across studies that social relationships were a source of both strength and problems, the latter undermining mental wellbeing. Good relationships with family (including extended family) and friends were viewed as important components of mental wellbeing.

The need to feel 'normal' is a thread running through many accounts, a factor which increases with the age of the young person as the peer group becomes more and more important to them. A lot of effort at this life stage goes into being 'like everybody else'.

Change of context and setting or environment could provide both positive and negative triggers in relation to mental health. The transitions of young people who moved through or into a different life phase also posed challenges to mental health, so anticipated changes from primary to secondary school or the leaving school transition were difficult, as were unanticipated transitions caused by events like illness or pregnancy.

Another cross cutting theme which runs across many accounts, but which comes through very starkly in work with troubled young people, is the need to exert some level of control over what is done to them and by whom. This was threaded through the accounts of normal school life – that children felt they did not have much say in what they did – but is very clear indeed where young people are in care or have acknowledged that there are concerns about their mental health and are trying to access treatment.

Implications of the findings for the mental health indicators framework
The findings are briefly reviewed against the draft framework for the children and young people's mental health indicator set.[1] On the whole the findings presented map reasonably well into the draft framework. At the level of the self or individual there is endorsement for the categories of healthy living (specifically physical activity/sport) and general health as being critical to mental health. Evidence was not found in young people's own accounts about spirituality. In relation to emotional intelligence, children and young people talked about having energy and being able to engage and about being in control of their emotion and feelings, some of which may equate to the term used in the framework, though this would not be one used by children and young people. On the individual level the framework captures least well young people's own critical sense of needing to be 'normal'. This need defines appearance and conduct at many points in children's lives and makes it doubly difficult to bear the cross of any 'difference' or stigma.

At the family level of the framework the concentration in children and young people's accounts is on relationships rather than structure; the latter was almost never mentioned as critical. Young people with a mentally ill parent were critically aware of their own role as a carer for their parent and of having to live a life adapted to the parent's condition.

The school level of the framework emphasises environment, peer relationships and engagement. Environment was occasionally mentioned, but relationships with teachers were seen as particularly critical. Children and young people agree on the importance of peer relationships at school, but most would make a distinction between the peer cohort or year group at school and their circle of friendships. This is not reflected properly in the draft framework. The school level of the framework does not currently reflect the stress that young people feel in relation to testing and achievement and the management of all school related activities within a timeframe.

Children and young people identified another group of adults who impact on their mental health, namely teachers, school nurses, counsellors, therapists. Their relations with young people could be critical, especially where young people had diagnosed or incipient mental health problems.

---

[1] See Table 1 in the main report for the draft working framework for the children and young people's mental health indicators

At the community level of the framework young people were more likely to stress the provision of facilities and activities and to equate the lack of these to boredom and poor mental health.

At a structural level, poverty and its manifestation through homelessness, the inadequacy and stress of life on benefits and so on were seen as lying behind the poor mental health of parents in some cases, and homelessness was directly related to mental health problems amongst young self-harmers.

1 Introduction

This study was commissioned in order to examine what children and young people themselves perceive to be important in affecting their mental health for good or ill and was undertaken in the form of a systematic review of both published peer-reviewed and 'grey' literature. It forms part of a wider piece of work being undertaken in Scotland to develop a set of national mental health indicators for children and young people which will help track year on year change in the mental health and its associated contextual factors of this important group.

This introductory chapter starts with a section looking at the context in which the review was commissioned. This includes a short overview outlining the policy context and what we know about changes in children and young people's mental health as a prelude to a section outlining the decision in Scotland to develop a set of indicators to measure changes in children and young people's mental health and associated contextual factors that impact on this. Terminology is clearly crucial and a third section discusses this in some detail, particularly because the different ways in which mental health terms are used will be a significant issue in discussing the review findings.[2] The chapter concludes by looking at some previous work which acts as a base upon which the current review is able to build and finally includes a section outlining the structure of the report.

1.1 The context

Improving the mental health of children and young people is a national priority in Scotland, as indicated most recently in *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 (TAMFS)* (Scottish Government, 2009) and *Better Health, Better Care: Action Plan* (Scottish Government, 2007a). There is a growing literature focusing on support for the mental health of children and young people in which a broad consensus is evident that all those who work with children and young people have a responsibility towards the inter-related issues of mental health promotion, prevention and care (Public Health Institute for Scotland, 2003). Recent legislation, *The Schools (Health Promotion and Nutrition) (Scotland) Act 2007* (Scottish Government, 2007b) came into force in January 2008 and places an obligation on local authorities to ensure all schools are health promoting. In tandem with this legislation the new *Curriculum for Excellence* places a stronger curricular emphasis on health and wellbeing and also underpins all school activities with a commitment to health and wellbeing (Scottish Executive, 2004a).

[2] NHS Health Scotland uses 'mental health' as an overarching term covering both mental health problems and mental wellbeing – see section 1.3. The terminology adopted by NHS Health Scotland is used throughout this report except in some instances where reporting on others' research where their language has been retained

In addition to this, recent government policies focusing on children and young people have demonstrated a commitment to early intervention. The *Getting it Right for Every Child* (Scottish Executive, 2004b) programme is founded on principles of early intervention, that is, appropriate, proportionate and timely intervention and provides a framework for putting them into action for all children and young people at the individual level. Similarly, within the education system through *Curriculum for Excellence (*Scottish Executive, 2004a*),* the *Early Years Framework (*Scottish Government, 2008*)* and within the NHS through *Health for all Children (*Scottish Executive, 2005*)*. These principles also underpin work to provide *More Choices and More Chances* (Scottish Executive, 2006) for children and young people at risk.

School responses across the United Kingdom (UK) include an emphasis on whole school approaches such as emotional literacy (Weare, 2004), in tandem with targeted and indicated interventions for those deemed to require additional support. The National Institute for Health and Clinical Excellence (NICE) has recently produced public health guidance reviewing the evidence for universal and targeted approaches to promoting mental health in primary schools and making recommendations for action. The NICE research that has been undertaken (Shucksmith *et al.,* 2007; Adi *et al.,* 2007) provides valuable meta analysis of 'what works' or is most effective based on reviews of existing work, but systematic review is always likely to underestimate the processes at work, and the type of evidence favoured by such reviews can lead us to disregard essential issues about the implementation of such programmes.

Efforts to improve or address children and young people's mental health are based on a tacit assumption that there is a problem that needs solving. Recognition of the extent of their needs in respect of mental health is just beginning to emerge:

> "It has only recently become clear that mental ill health among children and adolescents is not confined to only a small proportion of young people, but is surprisingly common. Although mental disorders may not constitute catastrophes that disrupt young people's lives and futures, they cause much suffering, worry and disturbance and they can be precursors of severe disorders in adults." (World Health Organization, 2004)

Concerns over the mental health of children and young people in the developed world have thus mushroomed in the last decade, with the reporting of some alarming figures. For example, an estimated two million children and young people in the European Region of the World Health Organization are said to suffer from diagnosable mental health problems (mental disorders) (World Health Organization Europe, 2005).

Worldwide, measures of children and young people's mental health vary and are influenced by social and cultural factors. There is also a lack of consensus or shared understandings as to meanings (Rowling, 2002). The United Nations *Convention on the Rights of the Child*, Article 1 states:

> "For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"

but this rather legalistic definition is far from being consistently used, and indeed would be considered disrespectful by many authors of work on young people's issues. Consequently, there is a huge variability in the way in which the terminology relating to 'children' and 'young people' is used between the studies reviewed here and this means that the review has had to use the terms interchangeably. The mental health of the youngest children is rarely measured, not least because of questions over the validity of standard self-report instruments and inventories with younger age groups. Who is included at the top end of the age range is also equally variable. In this review we aimed to focus on the age group 0 to 17 inclusive, but exercised discretion and flexibility if studies reported on work with samples aged up to 24 years generally. In a small number of cases age in the samples stretched to 25 or even 35, but to exclude them would have been to exclude the views of those children and young people that lay within the appropriate age category, as reports rarely differentiated between results emerging from different age bands of young people.

If there is debate about definitions of 'child' and 'young person', there is probably as much dissent over what constitutes 'mental wellbeing' or 'mental health problems' in children and young people and the terminology used (mental health terminology is discussed further in section 1.3). Bayer and Sanson (2003) within the Australian context discuss the difficulties of estimating the prevalence of childhood emotional problems but suggest that "up to one young person in five from the general population there has an emotional disorder at some time in their childhood". They suggest that this may be an underestimate and that evidence suggests that prevalence may be greater among those born more recently, so the problem may increase in the future.

In the UK some agencies claim a decline in the mental health of children and young people over the last 25 years (Mental Health Foundation, 1999). However, as West and Sweeting (2003) point out "conclusive evidence on the issue is actually in very short supply." One of the reasons for this lies in the methodological difficulties associated with researching this area. Recent research by Collishaw *et al.* (2004) draws on data from three large scale national longitudinal surveys in the UK over a period of 25 years between 1974 and 1999. Findings indicated increases in conduct problems across all social groups and family types for both boys and girls, more especially for what they termed 'non-aggressive' (stealing, lying, disobedience) than for 'aggressive' conduct problems

(fighting, bullying). Their findings indicate that emotional problems (misery, worries, fearful of new situations) remained stable between 1974 and 1986 but increased in the period 1986 to 1999, again for both boys and girls. The authors also suggested a link between conduct problems in adolescence and 'multiple poor outcomes' in adulthood. While the research has attempted to overcome some of the limitations of previous studies in this area, for example, using comparable measures of mental health over the period of investigation, the findings should still be interpreted with caution. Work currently being carried out by the Nuffield Foundation is also attempting to take a longitudinal view of changes in young people's mental health.[3]

Recently, the 2004 Office for National Statistics (ONS) survey of the mental health of children and young people in Great Britain found that one in ten children and young people aged 5-16 are reported to suffer from a clinically diagnosed mental health problem (Green *et al.,* 2005). This was the same proportion as had emerged from the 1999 survey. Boys were more likely than girls to have a disorder and there was considerable variation by family characteristics.

The problems of definition and measurement of population level rates of mental wellbeing in children and young people are highlighted, for instance, by the publication of the Innocenti Report Card (UNICEF, 2007). This study used existing data sources of a very variable nature across different jurisdictions to assess 6 dimensions of child wellbeing in the richest countries of the world. Most of these dimensions relate to contextual factors for mental health rather than assessment of mental wellbeing. The exception is dimension 6, a sense of subjective wellbeing, a composite indicator which includes two personal wellbeing indicators capturing aspects of mental wellbeing but not its entirety. Of these two personal indicators, for life satisfaction the UK emerged a sad 16th out of the 21 OECD countries, and lower than two non-OECD countries. Whilst the methodology in the report can be easily criticised, the report did have the effect of sounding an alarm call to governments in the UK. It was time to have a look at children and young people and be clear what their state of wellbeing (including mental wellbeing) was and to see whether it really was getting worse or getting better.

In spite of the proliferation of work to support mental health, therefore, there is only limited information available to allow us to track any national or local changes in the mental health of children and young people. Information is also needed on the associated contextual factors which impact on the mental health of children and young people. It is for this purpose that NHS Health Scotland is developing a set of indicators, which will be informed by this literature review.

---

[3] See www.nuffieldfoundation.org/go/grants/amh/page_392.html

1.2 Developing a set of indicators

To provide a means of assessing the mental health of Scotland's population and its context, NHS Health Scotland was commissioned by the Scottish Government to establish a set of national mental health indicators for Scotland that could be used to create a summary mental health profile for Scotland. A set of 55 indicators for adults was finalised in December 2007 (Parkinson, 2007). These are being used to determine whether adult mental health is improving in the Scottish population and to track progress. The set includes indicators to assess both the state of mental health of the adult population (mental health problems and mental wellbeing) as well as the level of associated contextual factors (at individual, community and structural levels) that impact on this. The first systematic assessment using these indicators was published in February 2009 (Taulbut *et al.,* 2009).[4]

NHS Health Scotland has now initiated work to establish a similar set of mental health indicators for children and young people in Scotland. This programme of work will be completed by April 2011 and the indicators will be developed at a national level, will be relevant to children and young people aged under 18 and will be relevant to the general population of children and young people (rather than to specific sub-groups of vulnerable children for example).[5] Commitment to these indicators was clearly set out in *TAMFS* (Commitment 4) (Scottish Government, 2009).

It is intended that the indicators will be structured within a modified adult mental health indicators framework that will be established early on in the work. The draft working framework used as an initial starting point for the development of the final children and young people's framework (and available at the start of this review) is shown in Table 1.

Within this the indicators will be structured under constructs (categories) of two types:

1. High level constructs – state of mental health
2. Contextual constructs – covering the contextual factors (risk and protective factors or the consequences of mental health), which may be at an individual, family, school,[6] community or structural level.

[4] For information on the adult mental health indicators work and outputs see www.healthscotland.com/scotlands-health/population/mental-health-indicators-index.aspx.
[5] For further information on the work see www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx.
[6] Since the start of this review, the term used for this domain has been revised to 'Learning Environment'. Other revisions to the draft working framework have also been made following discussions with the children and young people's mental health indicators advisory group.

Table 1: Draft working framework for the children and young people's indicator set

HIGH LEVEL CONSTRUCTS				
Mental wellbeing		Mental health problems		
CONTEXTUAL CONSTRUCTS				
Individual	**Family**	**School**[6]	**Community**	**Structural**
Learning and development	Family structure	School environment	Participation	Equality
Healthy living	Family relations	Peer relationships	Social networks	Social inclusion
General health	Parental behaviour	Engagement	Social support	Discrimination
Spirituality	Parental mental health		Trust	Physical environment
Emotional intelligence			Safety	Violence

The children and young people's programme of work was launched at an event at the Glasgow Royal Concert Hall on 21st April 2008. At this, delegates highlighted the importance of using children and young people's views of the factors that influence their mental health to inform the development of the children and young people's indicator framework and the indicators themselves (Parkinson, 2008). By including the views of children and young people in development of the indicators, the work respects the rights of children and young people to be involved in decisions made about themselves (United Nations, 1989). It also acknowledges developments in the sociology of childhood, which acknowledge children and young people's capacity to construct their own understanding of, and exercise agency within their world (James and Prout, 1997).

A literature exists on what children and young people view as factors that influence their mental health which can be used as a basis to inform the indicators work. This has been reviewed by Harden *et al.* (2001) up to 1999 (see section 1.4). NHS Health Scotland therefore commissioned research in November 2008 to critically review the literature (published peer-reviewed and 'grey') since 1999.

The literature review described in the report that follows will be one method employed to inform the development of the framework and the indicators of these views. At subsequent consultation stages, the NHS Health Scotland mechanisms for engagement with children and young people will be used to

determine directly the views of children and young people on the proposed final framework and indicators. Decisions on the framework and indicators will also be informed by discussions with the children and young people's mental health indicators advisory group, by the availability of national data, the evidence-base, policy and by wider consultation with researchers, practitioners, policy makers etc.

1.3 What is meant by mental health?

There are many definitions of and terms used for mental health. In NHS Health Scotland 'mental health' is used as an umbrella term to refer to both the concepts of mental health problems and mental wellbeing. This is consistent with a dual continuum model of mental health in which mental health problems and mental wellbeing are viewed as two separate continua, rather than as ends of the same continuum (Tudor, 1996). For the children and young people's indicators work, therefore, mental health is being used as a broad, overarching concept encompassing both indicators for mental wellbeing and mental health problems.

The term 'mental health problems' is used here to refer to symptoms that meet the criteria for clinical diagnosis of mental illness, or symptoms at a sub-clinical threshold which interfere with emotional, cognitive or social function. Examples include common mental health problems such as depression and anxiety, and, severe and enduring mental health problems such as schizophrenia. The term 'mental health problems' is, however, often used interchangeably in the literature with mental health, negative mental health, mental illness, mental ill-health, mental disorder and mental distress amongst others.

There is greater variety in definitions of mental wellbeing; however, most tend to emphasise that mental wellbeing includes aspects of subjective wellbeing (affect and life satisfaction), and psychological wellbeing (which covers a wider range of cognitive aspects of mental health than affect and life satisfaction such as mastery and a sense of control, having a purpose in life, a sense of belonging and positive relationships with others) and covers both the hedonic and eudaimonic perspectives of wellbeing. The term 'mental wellbeing' is often used interchangeably with mental health, positive mental health or wellbeing.

While 'mental health' and 'mental health problem' and 'mental wellbeing' are terms used within health services, schools tend to use the term 'emotional and behavioural difficulties' (EBD) or 'social emotional and behavioural difficulties' (SEBD) to refer to a range of difficulties that can create barriers to children's learning and 'social and emotional wellbeing' when referring to mental wellbeing. Children and young people may be influenced by terminologies thus used to describe them in a school setting, but may also use lay terms or talk in very general terms about their 'happiness' or 'health'.

An essential part of scouring the literature for children and young people's <u>own</u> understandings of mental health was to try to eliminate those studies which had forced an <u>adult</u> framework (of mental health problem diagnosis categories for example) on young people's thinking. Of even more interest were those studies that had not used adult-centric or 'leading' terms at all in trying to elicit young people's views. Inevitably, however, the elicitation of ideas and concepts in young people's own language exacerbates the problem regarding the multiplicity of understandings about mental health that we have discussed in this section.

The terminology adopted by NHS Health Scotland is used throughout this report except where reporting on others' research. In these instances, it has been important to remain true to the language used by children and young people (and occasionally that of the author(s)).

1.4 Existing work on children and young people's views of mental health

As indicated, there is already a literature on the views of children and young people in relation to the factors that influence their mental health that can be used as a basis to inform the indicators work. Harden *et al*. (2001) reviewed the literature (published peer-reviewed and 'grey') for the UK up to 1999 for individuals aged 11 to 21.

Harden *et al*.'s (2001) systematic review of research on barriers and facilitators to young people's mental health, undertaken for the EPPI-Centre, had a special focus on those from socially excluded groups and was a broader review than that required here, reviewing a range of trials and other forms of research which had been undertaken around the topic. Only one chapter (Chapter 6) deals with studies which examine children and young people's own accounts. The Harden *et al.* review included twelve UK studies of young people' views carried out up to 1999. The authors note that a number of these claimed to have recruited young people from different social backgrounds, but it was common for few details to be reported about methods of data collection and analysis. They conclude that the studies reviewed contained "some useful pointers to aspects of young people's perspectives on mental health that were not recorded in other types of studies". A major problem that they note is the futility of asking children and young people about mental health which young people tend to equate with mental health problems (and so as a problem belonging to other people and not relevant to their own lives). Harden *et al.* conclude from their reading and analysis, however, that young people in the studies had surprisingly sophisticated understandings of useful coping strategies and a wide range of concerns, from unhealthy school practices to environmental pollution and poverty. Disappointingly for the health promotion community perhaps, Harden *et al.* also note the irrelevance of many traditional health promotion materials and approaches to young people's pragmatic, everyday worries and interests.

Harden and his colleagues were able to compare children and young people's views on what was and wasn't important to them with the sorts of health behaviour interventions designed to address their problems that they had also reviewed. Whilst effective interventions were identified which addressed to some extent young people's concerns about teachers, parental divorce and conflict; bereavement; and peer rejection, they noted major gaps regarding the identification of effective interventions which addressed young people's concerns about workload, academic achievement and engagement in school, future employment (or unemployment) and financial security, having access to basic rights, resources and support, leisure facilities, dealing with the loss of friends and family, violence and bullying, and, finally, physical appearance.

Apart from these omissions in substantive areas a further gap was the failure to identify effective interventions which built on talking to friends as a favoured coping strategy.

Young people's relationships were found to be important in ten of the twelve studies. The quality of friendships and family relationships and the notions of 'having someone to talk to' were deemed to be important.

It is well known that certain groups of young people are more likely to experience poor mental health, for example, looked after children, lesbian, gay, bisexual and transgender (LGBT) young people, those living in poverty, those whose parents have mental health problems, or abuse alcohol or drugs (Public Health Institute for Scotland, 2003). Harden *et al.* (2001) identify the shortage of studies which examine the views of socially excluded young people. Given that the current review reported here is to inform the development of children and young people's mental health indicators for the general population, rather than specific sub-groups, it is important to be careful in using findings from groups with such specific interests or problems. A major difficulty in this respect is that most studies garnering young people's views are qualitative in nature and almost by definition use relatively small and non-representative samples.

1.5 Structure of this report

In the next chapter the project aims and objectives are specified and then in Chapter 3 the methods used to identify, assess and review the literature (published peer-reviewed and 'grey') are described. Chapter 4 develops a synthesis of the material to identify the themes noted most frequently by children and young people themselves as barriers to their good mental health or as factors which promot it. In the final chapter some of the more cross-cutting themes are discussed and the findings summarised briefly before the implications of the findings for the framework for children and young people indicators are considered.

2 Aims and Objectives

The aim of this piece of work was to critically review the literature on what children and young people view as factors that influence, either positively or negatively, their mental health.

The specific objectives of the review were to:

- scope the published and 'grey' literature on children and young people's views of the factors that influence, either positively or negatively, their level of mental health problems

- scope the published and 'grey' literature on children and young people's views of the factors that influence, either positively or negatively, their level of mental wellbeing

- critically appraise the relevant literature

- provide a summary of the main factors children and young people view as influencing their mental health, for both mental health problems and mental wellbeing, and to present these findings by age group and other relevant characteristics (to be informed by the results of the review).

3 Methods

In this section of the report we outline the methods used to locate, screen and synthesise the evidence that is used in the review.

The review was carried out in two phases. Phase one included scoping, searching and screening for relevance and quality of the published and 'grey' literature whilst phase two focused on the synthesis of evidence. Development of the search strings and strategies, inclusion/exclusion criteria and tools used was conducted in consultation with the steering group.

3.1 Phase one

3.1.1 Establishing search strings and searching for peer-reviewed literature

The first task was to establish the search string which would be used to conduct a systematic search of published peer-reviewed literature. This included generating a comprehensive list of words related to the topic under review. An initial list of keywords was taken from a previous review on this topic (Harden *et al.,* 2001) and the steering group suggested additional key terms. This initial search string was piloted in MEDLINE using a keyword search of the title and abstract. However, this approach was found to be too sensitive, therefore the string and strategy were altered to make it more specific. This was done by searching primarily using subject headings for each database and supplementing these with additional keyword searches of the title and abstract, if the database subject headings did not adequately cover each of the dimensions required by the project's objectives.

There were three main components to the search string with search terms centring on:

- children and young people
- mental health (mental health problems and mental wellbeing)
- views and opinions

Appendix 1 lists the final search strings. A decision was made to search only generic terms for mental health and to include only very common terms for 'types' of mental health problems such as depression and anxiety and 'aspects' of mental wellbeing such as life satisfaction and self-esteem. This was to limit an otherwise vast field of study. Literature on vulnerable groups was not specifically searched for but was considered for inclusion if identified through the search.

The subject headings and keywords for each component were combined with the Boolean operator 'OR' and then the results of the three components were combined using the Boolean operator 'AND' to focus the search. Finally, limiters were applied to further focus the results obtained (see below for limiters).

In total six databases were used to conduct the final search; the Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), International Bibliography of the Social Sciences (IBSS), MEDLINE, psycINFO, and the Social Sciences Citation Index (SSCI). As databases were provided by different hosts each required a different approach to searching. Advice about the most appropriate ways of conducting the search was taken from the University of Teesside librarian and a colleague who specialises in systematic reviewing. Adapting the search to each database also helped focus the results to become more sensitive and specific. In each instance the database thesaurus was used to locate main subject headings which encompassed the keywords chosen to cover each of the above components. The scope of each of these main subject headings was assessed to check if it covered all of the aspects of the components for the search. If they provided sufficient coverage then these were the only terms used to search. However, if they did not, then additional terms were used and searched for at a title and abstract level (see Appendix 1).

Limiters were utilised to reduce the number of irrelevant hits. In general terms these were:

- Language: to limit results so that only papers written in English were retrieved

- Date: to limit results to papers published between 1999 and the end of 2008

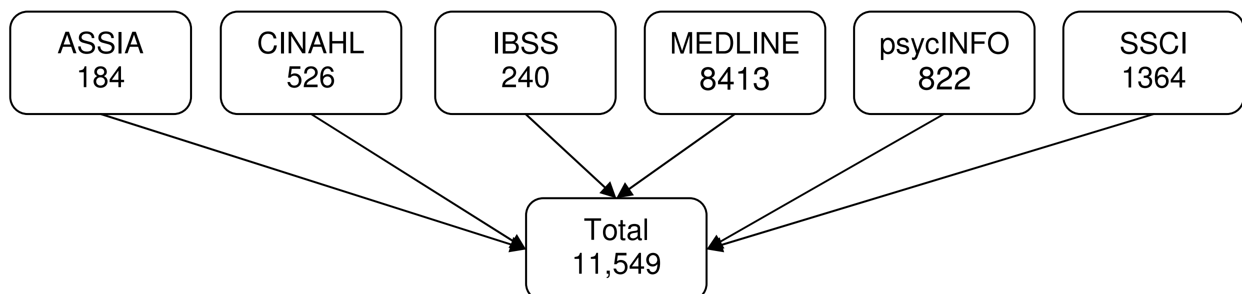
- Age of participants: to limit results to papers concerning children and young people under the age of 18. In the majority of cases we were able to limit age at a database level up to the age of 18 years. Upon reading the titles and abstracts this criteria was looked for again as a second check.

- Type of result: to limit results to peer-reviewed papers only.

Limiters are, however, different for each database, see Appendix 1.

The number of results returned from each search can be seen in Figure 1.

Figure 1: Databases searched and number of results



3.1.2 Screening abstracts for relevance and inclusion

Overall, 11,549 results were obtained through the initial database search. The titles and abstracts from each set of results were printed and the initial screening process was applied. Upon reading each abstract, the primary inclusion criteria was applied as follows:

Were the authors reporting:

- children and young people's own understanding of mental health or,
- children and young people's own understanding of factors that contribute to or are detrimental to their mental health?

Once the reviewer was satisfied this primary inclusion criteria was met the remainder of criteria were applied at an abstract level;

- language – written in English (if not already removed at search stage by using limiters)
- peer-reviewed (if not already removed at search stage by using limiters),
- primary research
- age – 0-17 years old inclusive (if not already removed at search stage by using limiters). It was decided, however, that flexibility could be given to the upper age limit of the sample up to the age of 24 if the sample also included those aged under 18. In two exceptional cases papers were included that utilised participants up to ages 25 and 35, as to exclude them would have been to exclude valuable data on younger participants
- developed country (as defined by the world bank as countries of 'high human development' i.e. an HDI score of >0.8)
- date – 1999-2008 (if not already removed at search stage by using limiters).

These criteria were developed to eliminate studies which were not relevant to the topic i.e. concerned with young people's own views and understandings of mental health problems and mental wellbeing, or were from countries where it would be difficult to generalise findings to a Scottish population. It was decided that if the literature search identified sufficient studies with UK populations, studies from other developed countries would be excluded from the review. However, if the search returned very few studies from the UK, primary focus would be applied to these but studies from other developed countries would also be included within the review. The latter was the case. A copy of the inclusion/exclusion criteria tool can be found in Appendix 2.

The first one hundred abstracts which were obtained from the search of psycINFO were assessed by all members of the steering group and the research team to ensure that agreement was obtained on which articles met the inclusion criteria and should be taken forward into the next stage of the review. This also enabled the appropriateness of the search string to be checked. If there was any doubt about an abstract meeting the criteria, then a full copy of the article was

obtained and re-assessed against the inclusion criteria. It was decided after reviewing the 100 abstracts that papers which were correlational in design or reported answers to pre-defined scales were not relevant to the review. Therefore, any such papers were also rejected and discarded. Once agreement was obtained about the use of the criteria and the suitability of the search terms and results, all abstracts returned from the database searches were screened by two members of staff against the inclusion/exclusion criteria tool.

If an abstract met all of the inclusion criteria a copy of the full article was obtained and it progressed to the next stage of the review. Also, if there was any doubt about an abstract satisfying the criteria from the information provided within it, a full copy of the paper was obtained and scrutinised against the criteria again. All abstracts which did not meet the inclusion criteria at this stage were discarded. In total 32 peer-reviewed papers were taken through to the quality assessment stage of the review. Four papers which were ordered through the Inter Library Loan system did not arrive in time to be assessed. These were in fact scrutinised after the report had been drafted but were not found to be relevant to the study.

3.1.3 Quality assessment of peer-reviewed literature

Each article which was deemed to be relevant to the review and had met each of the inclusion criteria was then subjected to an assessment of quality. All 32 articles were reviewed by a 'primary reviewer' and a selection of papers was reviewed by two additional reviewers to ensure that agreement was reached and the research team were working to the same standards. One hundred percent agreement was reached between reviewers about the quality of each article.

Each paper was read and scored against a set of quality criteria using a quality assessment tool adapted from the NICE framework (2006). This tool was adapted so that it could be used for both quantitative and qualitative studies. It focused on quality of the aims of the paper, study design, recruitment and data collection, data analysis, findings and interpretation and the implications of the research. Each paper was scored against the criteria, with three possible outcomes for each paper:

- high quality (++), where **all or most** of the criteria had been met and, where they had not been met, it was thought the findings of the study were very unlikely to change
- medium quality (+), where **some** of the criteria had been met and, where they had not been met, it was thought the findings of the study were unlikely to change
- low quality (-), where **few or no** criteria had been met.

These assessments did not constitute a numerical score. Rather, they were a judgement made by the reviewers based on the criteria set out in the quality assessment tool (Appendix 3).

All papers which were rated overall as either high (++) or medium (+) quality then progressed to the next stage of review, data extraction. Any papers which were classed as low quality (-) were rejected at this point.

3.1.4 Data extraction of peer-reviewed literature

At this stage of the review each article was subjected to 'data extraction' using a tool based on those from the EPPI-Centre (2007) (Appendix 4). Information regarding the aims of the study, sample, methods of data collection, method of analysis, findings and implications were drawn out using this tool. An example of the data extraction was reviewed before all papers were extracted to ensure all relevant information was included for the evidence tables. The evidence tables can be found in Appendix 6a.

3.1.5 Searching for 'grey' literature

For the purposes of this review it was important that an assessment of 'grey' literature was undertaken to complement the findings of the peer-reviewed literature. This is because a lot of work carried out at a national or local level or by agencies may not have been written up to be published in academic journals but nevertheless may include valuable information which could inform the review. Therefore, a web-based search was carried out to find any research which had been conducted by agencies from across the UK which was known to the research team and steering group to have an interest in young people's mental health. A full list of sites searched can be found in Appendix 5. All searches were conducted during November 2008.

Furthermore each agency was contacted via email by the research team to see if they had other publications which were relevant to the review which were not cited on their websites, or if they knew of any research carried out by people in their networks. There was a good response to this approach and many links to research were sent to the team. However, upon reading, much of the information received was not relevant to the scope of this review.

In addition the research team and steering group used their own professional and academic networks to seek out unpublished literature of relevance to the review. Personal emails were sent to other academic researchers with an interest in this field, for instance, and the opportunity was taken whilst participating in a Scottish Pupil Inclusion Network (PIN) seminar to publicise the ongoing work with practitioners. Further to this the Network organisers agreed to send an email message to all members in the network and it was then forwarded to other relevant agencies and networks. The steering group also approached the children and young people's mental health indicators advisory group and asked for their assistance in locating any 'grey' material of relevance.

3.1.6 Screening of 'grey' literature for relevance and inclusion

Eighty-two pieces of 'grey' literature were identified through the searching process. The same screening process was applied as was used for the peer-reviewed papers. The inclusion criteria were applied in the same way. If a piece of 'grey' literature was identified as relevant to the review after the application of the inclusion criteria it was taken forward to the next stage of the review, quality assessment. Eight studies met the inclusion criteria.

3.1.7 Quality assessment of 'grey' literature

The 'grey' literature which met the inclusion criteria was subjected to the same quality assessment process as the peer-reviewed literature. This process had to be as stringent as the process for peer-reviewed literature so as not to undermine the overall process and quality of evidence taken forward to the synthesis phase.

This stage was undertaken in the same manner as before, with one reviewer applying the quality assessment tool to all articles and reports and a sample checked by a second reviewer. A sample of the 'grey' literature was also cross checked by the research team and steering group members to ensure that using the same quality criteria as the peer-reviewed papers was appropriate for use on 'grey' literature.

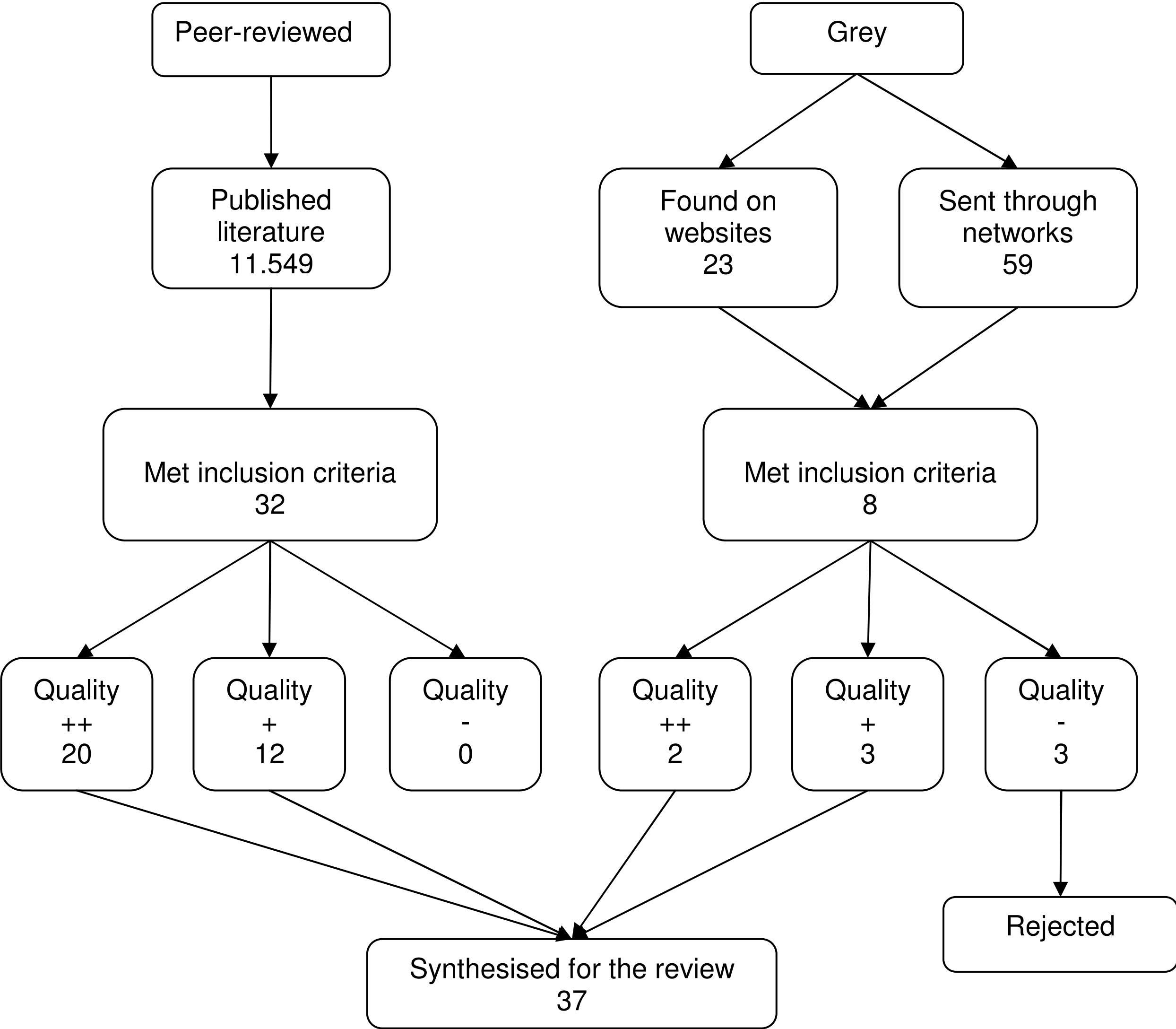
Papers were once again graded against individual quality criteria and assessed overall as either high (++), medium (+) or low (-) quality. The five assessed as either high or medium quality (++ or +) were taken forward into the data extraction process.

3.1.8 Data extraction of 'grey' literature

Again, to ensure that all pieces of literature taken forward to the synthesis stage were treated equally, the same process of data extraction was applied to the 'grey' literature. The information from this stage of the review was used to populate the evidence tables which can be found in Appendix 6b.

A full list of the number of articles taken through at each stage of phase one can be found in Figure 2 below.

Figure 2: Number of papers retrieved at each stage of review



3.2 Phase 2

3.2.1 Approach taken to synthesis of the literature

Following the sifting process of quality assessment, researchers read all the papers, and independently identified key themes. Our readings were informed by the project research brief, and by our existing knowledge of the field of young people's mental health. However, care was taken to avoid simply seeking themes that would fit neatly into existing frameworks, as an important remit of the review was to establish themes emerging from the views of children and young people in the literature. Discussion between researchers led to the identification of repeating themes, conflicting evidence and unexpected findings. A framework for reporting was agreed by the research team.

Choosing a framework for reporting was not straightforward, as factors which children and young people see as impacting on mental health are interconnected and overlapping. For those in difficult circumstances e.g. children and young people with experience of depression, there was an accumulation of contributory factors. Therefore, however the emerging issues are categorised this is inevitably an oversimplification of what is a complex field. Within the synthesis of the literature presented here there are many cross references between sections, and whilst we seek to avoid repetition, some issues are mentioned in several places within the reporting framework. The themes of identity, relationships, social networks and connectedness, time and timing come through very strongly and overlap with other topics.

3.3 Methodological approaches of the papers reviewed

The papers reviewed were drawn from across the developed English-speaking world, with only a minority (n=9 peer-reviewed papers) of research being located in the UK. A range of different approaches to data collection and analysis were evident. The bulk of the papers adopted purely qualitative approaches (n=26 peer-reviewed papers) with fairly small samples, and laid claim to 'grounded' analysis, where emerging themes were led by the data. However, the professional frameworks of the researcher(s) were strongly evident and these led to different perspectives and foci within the papers, which in turn impacted upon the analytical processes. The majority of the papers were written by researchers with a nursing or health care background, and aimed at improving the service they could offer to young people as individuals. Some were written from the point of view of psychological or psychiatric services with a similar aim of improved responses to individual children and young people in need of support. A minority of papers take a 'youth studies' approach looking at underlying processes and recognising the complexity/diversity/heterogeneity of children and young people.

Different conceptualisations of children's competence and agency emerge. This is evident in the methods used for data collection. For the most part data are gathered through the types of methods which might be used with adult participants, such as individual interview, or focus group discussion, to consider an agenda which was determined by the researcher. Few researchers have drawn from recent research thinking about participatory methods, or types of data collection which are more suitable for use with children and young people.

3.3.1 Different populations of young people

Some papers sample from the general population of children and young people within a particular setting (n=17), and identify issues affecting both mental health problems and mental wellbeing. Other papers focus on particular sub-groups of young people, who face certain issues, for example, young carers, or those with physical or mental health problems (n=15). The experiences of children and young people in the latter group tend to amplify issues identified by the general community. Therefore, we are looking at the experiences of young people on a continuum, rather than as fragmented groups.

3.3.2 Diversity within samples

Most of the researchers go to great pains to sample in a way which includes a diversity of young people, but few of the papers go on to comment on the differences between the perceptions and experiences of different groups. The age ranges vary both across and within the papers and are sometimes very wide. Yet the differences between the age groups are not always made explicit. Only a small number of papers make specific comments about the differences or similarities between age groups. Similarly a number of papers draw cross-cultural samples, but again in most cases do not fully explore the differences or similarities that emerge. Gender is not widely explored, in spite of many studies including boys and girls in their samples.

4 Results

In this chapter we present the results of the literature review and synthesis. Each section is preceded by a table listing those sources which contribute to the evidence-base in the section which follows. The table lists the quality rating for the item and also notes other important features about the sample whose views are represented, e.g. age, location of study. A simple set of bullet points describes the main findings in each section before more detailed analysis is given.

The ordering of the sections that follow starts from children and young people's understanding of terms like mental health and mental wellbeing. We then look at the factors that are internal or related to the self (positive and negative) that children and young people believe impact on their mental health. We then explore their views in relation to the positive and negative aspects of family relationships on children and young people's mental health. Their views in relation to schools and the general peer relationships experienced by young people in this setting are dealt with next, but peers and friends are two different things, so the following section looks more closely at the positive and negative impacts of friendship on support of mental health in this age group. Broadening out, we look at the evidence on children and young people's views of the potential for other adults beyond the family group to have an impact on mental health. Finally, we look at broader aspects of neighbourhood and community life, as well as more general structural pressures that children and young people see as significant in respect of mental health.

4.1 Children and young people's understanding of mental wellbeing

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Bourke & Geldens	2007	16-24, N=91, Australia	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Roose & John	2003	10-11, N=16, England	+

- Children and young people view mental health as comprised of both positive and negative factors

- They relate mental wellbeing to internal feelings about the self and to relational issues such as interactions with family, friends and others, as well as to external experiences and life events
- Young people report subjective wellbeing as ‘fluid’
- Their definitions focused on themes of being happy and feeling good about themselves
- Age is critical when asking children and young people about abstract concepts. Young people in their mid teens offered clearer views on mental wellbeing. Younger children are less clear about what is meant by terms such as mental wellbeing
- Having energy, well balanced emotions, being able to interact positively, and being in harmony at school and in other places are reported as demonstrating mental wellbeing.
- Being good towards others was seen as important to feeling good about yourself and being a ‘self-confident person’ was associated with mental wellbeing

What do children and young people understand by a terms like mental wellbeing? Papers included in this review show that children and young people see mental health as multifaceted and complex.

A Scottish study by Armstrong *et al.* (2000) analyses the views of 145 12-14 year olds living in rural, urban and inner city locations, with a sample which took account of the diversity of the Scottish youth population including socio-economic and cultural backgrounds. The authors found a level of confusion about the meaning of the term ‘positive mental health’ especially among younger children and those living in rural locations, and this led young people to focus on the part of the term that they were most familiar with.

Bourke and Geldens (2007) used the term ‘subjective wellbeing’, rather than mental health or mental wellbeing, to examine the perspectives of 16-24 year olds living in a rural area of SE Australia. Their study explored young people’s experiences and self-ratings of wellbeing and the meanings they attributed to this term. Overall, most young people rated themselves as very happy or happy. However, those who were service users (i.e. young people interviewed in youth centres or similar) differed considerably, rating themselves as having lower levels of wellbeing. Participants in such settings were likely to qualify their judgement about wellbeing with terms like ‘just now’ or ‘right now’, suggesting that wellbeing was fluid and subject to change.

A Swedish study undertaken by Johansson *et al.* (2007) had as a main question for children and young people ‘What do you think when I say ‘mental health’?’ Overall in this study children and young people described mental health as related to feelings and ‘about how you think’. Happy was a word commonly used by boys and girls. Girls expressed feelings of happiness such as feeling that time flies, having a lot of energy or that things are easily done. Boys used

expressions for feeling happy such as ‘light as a feather’. Other expressions like ‘having fun’ and ‘laughter’ were also related to this sense of being happy. Other expressions in relation to internal feelings of positive mental health included being in harmony, at school and in other places. This was expressed by a number of boys and girls. One girl noted that if you feel harmonious you also feel strong:

> “You have the strength to do anything and you want to socialise with people without wanting to go home and so on.” (16 year old girl)

Being nice and friendly, considerate and caring were important dimensions for young people, reinforcing their sense of being a ‘good’ person. Being good towards other people was seen as making you feel good about yourself.

Mental wellbeing was also associated with being a ‘self-confident’ person. A self-confident person interpreted remarks in a positive way, had strong self-esteem, could laugh at themselves. Being talented at something, being clever, being good looking were also seen as likely to give people self-confidence.

The Johansson *et al*. study reported that while 16 year old participants gave clear descriptions of the meaning of mental health, 13 year olds found the concept difficult to understand. Older boys and girls related mental health mostly to themselves, while the younger children described their feelings more in relation to other people, friends first and foremost, then parents.

Ten and 11 year old participants in Roose and John’s focus group study (2003) defined mental health as about having peace of mind and having one’s emotions well balanced. They also described it as complex, and attributed this to mental health being less visible than physical health.

4.2 Children and young people’s understanding of mental health problems

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Farmer	2002	13-17, N= 5, USA	++
Gallichan & Curle	2008	10-17, N=12, England	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Kendall *et al.*	2003	6-17, N=39, USA	++
Secker *et al.*	1999	Not recorded, N=120, Scotland	++

Shelton	2004	13-17, N=30, USA	+
Wisdom & Green	2004	14-19, N=22, USA	++
Woodgate	2006	13-18, N=14, Canada	++
‘Grey’			
Barnardo’s	2008	10-17, N=69, Scotland	+

- Young people found it easier to define poor mental health or mental health problems than mental wellbeing. As with mental wellbeing, poor mental health was felt to be a consequence of a wide range of environmental, relational and individual factors
- Young people described mental health problems as an accumulation of overlapping symptoms and signs, often drawing on their own experiences or those of people they knew
- Mental health problems were described by them as consisting of feelings of unhappiness, anxiety and depression. Once in this condition, a sense of listlessness and heaviness was overwhelming. Tiredness was characteristic.
- The onset of mental health problems was seen in part as deviation from the ‘norm’
- Those diagnosed with some form of mental health problem often expressed clear understanding of the nature of their conditions and offered coherent accounts of symptoms and treatment
- Children and young people with depression reported that being diagnosed with a mental health problem allowed access to services but brought with it a stigma which increased their vulnerability and was likely to stay with them and influence their life opportunities
- Young people with an ADHD diagnosis reported that the condition became a major part of their identity, defining them as ‘not normal’. However, medication also made them feel as if they were no longer their true selves.

Young people found it easier to define poor mental health than mental wellbeing. As with positive mental health or mental wellbeing, their definitions encompassed a wide range of environmental, relational and individual factors, with them feeling that problems were rarely caused by single factors, but often by an accumulation of issues becoming unbearable.

In Johansson *et al.*’s Swedish study (2007), both boys and girls described poor mental health as being the reverse of mental wellbeing. They talked about feelings of being unhappy. Other ways of describing this feeling were, for example, feeling depressed, being anxious, being ‘worn out in your spirit’, wanting to hide, things feeling ‘heavy’. Boys talked of feeling antisocial, irritated and dejected. Having a feeling of lack of meaning and hope was something mentioned by the older girls; younger ones did not seem to think in these terms. Wisdom and Green’s study participants (2004) similarly describe this sensation

as ‘being in a fog’, ‘having a cloud over’ them, ‘dragging’ along and ‘feeling a weight on them’.

Older boys and girls in Johansson *et al.’s* study mentioned feeling stressed and having no self-confidence. The girls described this feeling as also about being angry with oneself, feeling blameworthy and unwanted. Many mentioned lacking energy and experiencing extreme tiredness. The authors framed this as ‘internal feelings’. Similarly young people’s descriptions of being disliked (bullied/lonely), feeling abandoned and friendless, being unhappy at home were categorised as ‘relational feelings’.

Secker *et al.* (1999) in a Scottish study, note that their participants defined the onset of poor mental health at least in part by a deviation from the norm. Thus, where someone was behaving in an unusual way (e.g. shouting in the street) it might be an indication that a mental health problem was present. Similarly, if someone who normally cared for their appearance suddenly couldn’t be bothered to wash their hair or put on make up it could be a sign that they were becoming listless and apathetic and sliding into poor mental health.

Those with experience of mental health problems are clearly likely to have a better understanding of what poor mental health means to a young person. Wisdom and Green (2004), for instance, explored how young people diagnosed with depression experienced, interpreted and understood their condition. Fifteen young people (8 males and 7 females aged 14-19) with a depression diagnosis were recruited in the Oregon/Washington area of USA. The majority were white and two came from Hispanic backgrounds. Most were no longer in active treatment for their condition. A key finding reported by participants was that depression accumulated over time, with some looking back to a very different early period before becoming depressed. Some explained and understood their depression as being related to specific life events such as parental separation, medical issues, child abuse, the death of a relative or friend. They also suggested an association with changes at adolescence, recognising that these exacerbated difficulties which would otherwise have been dealt with ‘normally’.

Similarly, Farmer (2002) examined the views of three young American women and two boys from Caucasian, Hispanic and Afro-American backgrounds aged 13-18 with diagnoses of depression. Participants described fatigue, anxious misery, loss of academic success and self-esteem. Feelings of isolation were related to feeling a loss of connection with family and friends. Linked with this was their understanding that their homes lacked safety and affection. For some this related to abuse; for others it was simply the absence of parents. Anger associated with depression was a recurring theme and was most frequently described as being directed at parents, siblings, and teachers. On the one hand this was seen as bad in that it could lead to serious and negative consequences, but on the other it served as the classic ‘cry for help’, alerting others to the need for intervention and treatment.

Shelton (2004) examined the experiences of detained young offenders from minority ethnic groups in a North American setting. Participants reported that the stigma of a diagnosed mental health problem was very powerful, leading some to believe that being labelled as mentally ill left them with little hope for the future. They felt that seeking help was likely to increase their vulnerability by making them visible to others but also that potential helpers could not be trusted to respect confidentiality. Similar findings are reported in a number of studies (for example Woodgate, 2006; Wisdom and Green, 2004).

In a study by Kendall *et al.* (2003) young people with attention deficit hyperactivity disorder (ADHD) described their condition as being part of them, albeit a highly unpredictable and difficult to control element. Kendall *et al.* concluded that some young people absorbed the condition into their identity. For example, some children defined themselves as 'normal' but 'different' while the majority viewed themselves as 'not normal'. However, some interesting findings emerged among the three ethnic groups included in the sample. African American children in the sample described their ADHD identity as leading them to be 'bad': Hispanic children saw it as leading them 'into trouble' while Caucasians described it as 'weird'. Young people taking medication for their condition reported that it resulted in them no longer being 'themselves'. Gallichan and Curle (2008) also explored the experiences of young people diagnosed with ADHD. In this study medication played a major part in the accounts given by young people. Some young people tried to keep it secret in order to avoid unwanted attention, some felt they were not the 'real me' or were 'under a spell' when taking medication and this in turn made them feel they were different and not 'normal'.

Within the 'grey' literature the Barnardo's study (2008) makes an interesting contribution in detailing children and young people's understanding of their own behaviour when distressed and their awareness of the strategies they used to vent this or to cope with it, such as slamming doors, shouting, stopping eating or harming animals. Interestingly girls mentioned not eating whilst boys mentioned hurting animals.

4.3 Self: factors about themselves having an impact on children and young people's mental health

4.3.1 Positive factors about themselves having an impact on children and young people's mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145,	++

		Scotland	
Bourke & Geldens	2007	16-24, N=91, Australia	++
Ellis	1999	14-15, N=24, New Zealand	++
Farmer	2002	13-17, N= 5, USA	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Stanley	2007	12-19, N=14, UK	+
'Grey'			
Girlguiding UK	2007	5-25, N=3242, England	+
White	2003	9-24, N=77, Scotland	++

- Aspects of the self which contributed to mental wellbeing were identified as related to feeling healthy, positive and happy
- Body image and appearance were important, especially to young women
- A sense of personal achievement was critical. For many this related to school success, but for boys, success was often achieved through sport
- Some young people noted that the power of achievement in making them feel good and contributing to mental wellbeing was the recognition and regard it brought from others, particularly parents
- Having some control over, and understanding of, their emotions was important for some young people, but a sense of control over their own choices was important more generally in a number of studies.

In Bourke and Geldens' (2007) study in SE Australia participants reported that 'feeling good' was contingent on their feeling healthy, positive and happy, and on whether they were achieving their goals and feeling good about their relationships and how they looked.

Girlguiding UK (2007) asked girls and young women throughout their organisation, including those children in their youngest Rainbow section (aged 5 to 7), about their feelings by asking them to rate themselves on a happiness scale and to answer questions and vote in opinion polls to say what made them happy. The results highlight just how multifaceted happiness is construed to be with factors which are individual (self-focused) but also relational and material. In the first category, girls listed many things which were important to their mental wellbeing including being successful at school, university and work, and feeling attractive.

The Scottish Needs Assessment Project (SNAP) report (White, 2003) also included an element which collected children and young people's own views through qualitative discussion groups and interviews. Imaginative techniques like thought showering, voting on issues and drawing pictures were techniques used

to draw out their perspectives. Young people thus gave comprehensive lists of what made them happy, which varied with age, but echoes a great deal of the findings in the Girlguiding UK study reported previously.

The Swedish study by Johansson *et al.* (2007) noted the importance of physical appearance and looks to mental wellbeing, but particularly so for girls (both boys and girls in the sample agreed on this).

That success in school can contribute to feeling 'mentally healthy' was identified by Armstrong *et al.* (2000) in their study of young people (N=145) aged 12-14 who attended mainstream schools in Scotland. The opportunities that schools gave for both academic achievement and sporting success were seen as positively impacting on mental wellbeing. However, children and young people qualified this by saying that the sense of self-worth that accompanied school success was reinforced by recognition from friends and family, particularly parents. The authors noted that school success was mentioned mostly by boys, although the qualitative design of the study does not allow a statistical analysis. The report by Girlguiding UK (2007) also mentions being successful at school, university and work as good for mental wellbeing.

This finding is echoed by the work of Ellis (1999) with adolescents in New Zealand. Interviews with 14 year olds (N=24) linked high school marks to feelings of self-esteem. Again, one respondent qualified this by suggesting that it was not the marks *per se* that impacted on self-esteem, but the responses of others to such success or failure. No gender difference was reported in this study.

For boys personal achievement in relation to sport was also valued as contributing to feelings of mental wellbeing, whereas girls laid more emphasis on body image and keeping fit (Johansson *et al.,* 2007).

Having some control over their own choices and some sense of agency is mentioned in a number of studies by young people as critical to their wellbeing. Thus, Farmer's (2002) young depression sufferers needed to gain understanding of their condition in order to regain control of their behaviour. Similarly Stanley's young care leavers (2007) also felt better and mentally healthier when they could make choices about their treatment or care.

4.3.2 *Negative factors about themselves having an impact on children and young people's mental health*

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Earley *et al.*	2007	10-16, N=17, Ireland	++
Gallichan & Curle	2008	10-17, N=12. England	++
Kendall *et al.*	2003	6-17, N=39, USA	++
Lynch & Spence	2007	16-21, N=4, New Zealand	++
McCaffrey	2006	5-15, N=6, Australia	+
Shelton	2004	13-17, N=30, USA	+
Stanley	2007	12-19, N=14, UK	+
van Daalen-Smith	2008	14-24, N=65, Canada	+
Wisdom & Green	2004	14-19, N=22, USA	++
Woodgate	2006	13-18, N=14, Canada	++
'Grey'			
Girlguiding UK	2008	10-14, N=404, England	+

- Feeling bad about body image and physical maturation is identified by some young people as an aspect of the self that contributes to mental health problems, some of this being identified as arising from the pressures inherent in modern society's image of what young women in particular should look like
- Aspects of gender stereotypes in relation to expected behaviour from girls are identified in one study as the root cause of a great deal of anger in young women associated with mental health problems
- The need to 'grow up too soon' is identified as an additional problem by young women in one study
- Poor physical health experienced by young people with acute or chronic diseases is also associated with poor mental health
- Worries and concerns about their health and the potential outcomes are exacerbated by the fact that health problems render them abnormal in this age group and the lack of normality is almost as hard to bear, creating mental anguish, as the original illness

- The stress of being abnormal or having an abnormal 'childhood career' was also experienced by children and young people who had to act as carers or who were in care themselves
- Young people with diagnosed mental health problems experienced stigmatisation as a further assault on their mental wellbeing and felt that it sometimes took over their identity.

Girlguiding UK's (2008) study highlights the volatility of young people's emotions and feelings (subjects were 10-14 years old). Negative emotions were often associated with relational issues such as feeling unloved, excluded, left out or ignored, but features related to the self like body image and physical maturation also had a negative impact on feelings of happiness with many referring to the 'size zero' culture in which we now live.

Gender issues are also implicated in van Daalen-Smith's (2008) study, undertaken in Canada with a group of young women and intended to explore the roots of their anger with themselves and others. Young women expressed feelings about never having had sufficient encouragement, of being told they weren't very good, of being constantly compared to others, and the effect that all of this had on their self-esteem. However, when their anger at their treatment bubbled over, they found themselves 'in a Catch 22' as they described it, where any expression of anger from a girl indicated that she was not normal and brought down on them further judgement and what the author calls 'relational disruption'.

The Girlguiding UK's work (Girlguiding UK, 2008) also highlights young people's views on the negative impact of having to 'grow up too soon' in a world where young women (in this case) are bombarded by highly sexualised media images and where the pressure to dress and act like a grown up is exerted through consumer forces on even the youngest children.

The reverse of good physical health being a significant factor in bringing about mental wellbeing for children and young people is, of course, that poor physical health and illness may have a significant role to play in the onset of some mental health problems like depression. A number of studies reviewed here illustrate this point well, e.g. McCaffrey's (2006) work, as well as that of Lynch and Spence (2007) and Woodgate (2006). Feeling bad, worrying about their symptoms, about eventual outcomes and so on is to be anticipated in children with a chronic or life threatening condition, but sometimes it was simply the pain of being 'not normal' that created the mental anguish for these children and young people and distanced them from their peer group. One young girl cancer sufferer in McCaffrey's study commented "Wearing a hat everywhere at school and the constant questions."

Some sufferers were only too painfully aware that they had regressed emotionally as well as physically, becoming thumb suckers, needing a security blanket, becoming totally emotionally dependent on parents and so on.

Abnormality or having an abnormal childhood was also something recognised by children and young people who were themselves carers (of a sick parent) (Earley *et al.,* 2007) or who were in care themselves (Stanley, 2007), and many thought this injurious to their mental wellbeing.

For those with a mental health problem rather than a physical health problem, the stigma of being labelled often outweighed any benefit of having a diagnosis in their eyes. Some young people in the studies reported by Gallichan and Curle (2008), Wisdom and Green (2004), Kendall *et al. (*2003), Shelton (2004) and Woodgate (2006) clearly felt that their identity was compromised or 'taken over' by the diagnosis in a way which was itself injurious to their mental wellbeing.

4.4 The pivotal role of family relationships on children and young people's mental health

4.4.1 Positive impacts of family on mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Bourke & Geldens	2007	16-24, N=91, Australia	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Joronen & Astedt-Kurki	2005	12-16, N=19, Finland	++
Kendall *et al.*	2003	6-17, N=39, USA	++
Lee & Breen	2007	16-17, N=12, Australia	++
Lynch & Spence	2007	16-21, N=4, New Zealand	++
Sixsmith *et al.*	2007	8-12, N=24, Ireland	++
Shelton	2004	13-17, N=30, USA	+
Stanley	2007	12-19, N=14, UK	+
Woodgate	2006	13-18, N=14, Canada	++
'Grey'			

Barnardo's	2008	10-17, N=69, Scotland	+
White	2003	9-24, N=77, Scotland	++

- The theme of 'family' is present in many of the papers, but it is clear from children and young people's own accounts that relationships within the family can impact both positively and negatively on mental health
- In some papers 'friends and family' are conflated, suggesting that it is relationships that are important, rather than the structures in which those relationships are located
- Age may be significant in determining the comparative importance of family versus peers/friend to young people
- Remarkable consistency was evident in reports by children and young people about the importance of family relationships in creating and sustaining feelings of mental wellbeing
- Papers which explored the views of children and young people whose lives were made more difficult by problems with mental or physical health, or by being separated from their family, all identified the importance of family for the mental wellbeing of the participants
- Positive aspects of family relationships identified by young people as important are:
    - comfortable home
    - loving/trusting family relationships
    - open communication
    - familial involvement
    - external relations (life outside the family)
    - personal involvement in the family
    - sense of safety and security
    - support and 'buffering' against adversity
    - support in decision-making
    - being able to talk openly about difficulties
    - unconditional support in case of health difficulties.

Children and young people's accounts of factors that impact positively on their mental health often mentioned family, but in some cases there was little or no further elaboration than simply identifying the concept of 'family'. For example, 52% of respondents in Barnardo's (2008) Rollercoaster service report included pictures of 'family' in response to questions about what made them happy. Similarly, 19 out of 22 'younger children' in the consultation for the SNAP report (White, 2003) identified 'family' as a source of happiness.

In Sixsmith *et al.*'s (2007) study, children and young people aged 8-12 were invited to photograph things which contributed to their wellbeing (defined as 'feeling good, being happy, and able to live your life to the full'). Photographs were then categorised by another group of children, and subsequently arranged

in a schematic diagram which allowed for links to be drawn between categories and for rank ordering to be demonstrated. In this study 'family' was depicted in the diagram as being the most important of 25 categories. Other important features which were linked by arrows to the family were 'animals and pets', 'house and bedroom' and 'fun'.

A little more detail can be drawn from a Finnish study. When asked 'Which familial aspects contribute to adolescent subjective wellbeing?' the 12-16 year olds in Joronen and Astedt Kurki's (2005) sample identified six categories. These were: comfortable home, loving atmosphere, open communication, familial involvement, external relations (having a life outside the family) and a sense of personal involvement in the family.

Bourke and Geldens' (2007) Australian study explored 'the meaning of subjective wellbeing' by comparing two groups of young people, namely 'students' aged 16-18 and 'service users' aged 16-24. All acknowledged the value of family relationships, although the quality of relationships within the family was described as variable, particularly amongst the 'service users'. Here, the 'buffering' effect that families could have against difficulties was identified by those who felt their relationships with families were good. A practical example of the sort of support families may offer was described by Lee and Breen (2007) who explored the perceptions of Australian young people who left high school early. Decisions to leave school had been based on negative experiences of schooling but the support of parents in reaching decisions at a time of difficulty and through the transition to the workplace (where successful) was valued by respondents. This was not articulated in terms of 'mental health', but the importance of parental guidance and support in making a successful transition to the workplace was identified by the respondents.

In some studies 'friends and family' were presented as a single item and not further differentiated. For example in Armstrong *et al.*'s (2000) Scottish study, young people reported the value of relationships in general in the context of 'friends and family'. These significant people, it was reported, made them feel secure, supported and wanted, and prevented feelings of isolation. Sharing problems, and hence having someone to talk to, was also described by young people in this study as important for mental health, and here too friends and family emerged as centrally significant. Young people from Muslim/Pakistani backgrounds referred more often to relationships with extended family such as uncles and aunts as particularly important in times of difficulty.

Johansson *et al.* (2007) again identified friends and family as being important for mental health. This study involved semi-structured interviews which were based on the general question 'what do you think when I say 'mental health'?' Within the sample a difference was noted between two age groups. The younger girls and boys mentioned friends more often than they did family. The authors conclude that this indicates that these 13 year olds perceived friends to be more

important than family. However, the converse was true for the 16 year old girls, who placed more emphasis on family, whilst the older boys placed equal emphasis on the two types of relationship. The authors seem, in their analysis, to disregard the views of the younger children by suggesting that they were less aware of the world around them and therefore more likely to take their parents for granted, rather than compare themselves to other families. They go on to conclude that family is the most important determinant of mental health.

The pivotal role of families in supporting those children and young people with particular problems, for example, mental or physical health difficulties, was clearly evident across a number of papers. The struggle to maintain ‘a sense of belonging in the world’ identified by sufferers of depression, was reported by children and young people to be greatly supported by family members who stood by them unconditionally and treated them as ‘special’ (Woodgate, 2006). Similarly, children and young people with diagnoses of ADHD reported a reliance on their families, usually their mothers, to keep them safe, and to understand and help them (Kendall *et al.,* 2003). Similarly, sufferers of Crohn’s disease (Lynch and Spence, 2007) described their dependence on family members for support when the disease left them isolated or hospitalised, and how this dependence could lead to a deepening of the relationship. But these relationships were also prone to tensions as the children and young people sometimes did not wish to see people and rejected the attentions of the very people on whom they depended.

Finally, it is worth noting the views of children and young people who had been separated from their families. Two papers offer an insight in this respect. Firstly, Stanley’s (2007) study explored the views of children and young people (aged 12-19 years; N=14) in residential and foster care. A striking finding in this study was the way in which the children and young people identified strongly with their birth parents, especially mothers, in spite of the shortcomings that characterised the parenting they had received. Presented with vignettes of looked-after young people experiencing distress, the respondents suggested mothers as a primary source of support. However, the relationship was viewed with ambivalence, as many felt angry that they had been let down by their parents.

In a similar vein, Shelton (2004) found a desire for caring and stable families amongst a group of African American young offenders (N=30) who had been detained and deemed to be ‘in need of mental health care’. As with Stanley’s group of looked after young people, the respondents in this study indicated disappointment in their families, but retained a sense of the value of family relationships.

4.4.2 Negative impacts of family on mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Brobeck *et al.*	2007	11-12, N=29, Sweden	++
Clark *et al.*	2007	5-18, N=53, USA	+
Earley *et al.*	2007	10-16, N=17, Ireland	++
Farmer	2002	13-17, N= 5, USA	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Joronen & Astedt-Kurki	2005	12-16, N=19, Finland	++
Murray *et al.*	2005	12-19, N=128, USA, UK, Australia, Canada, Germany, New Zealand, Finland, Ireland, Japan, Belgium and Israel	+
Riebschleger	2004	5-17, N=22, USA	+
Ryan-Wegner *et al.*	2005	7-12, study 1 N=194, study 2 N=494, USA	++
'Grey'			
Barnardo's	2008	10-17, N=69, Scotland	+
Haydock	2001	16-21, N=46, Scotland	++
White	2003	9-24, N=77, Scotland	++

- Family discord (hostility, conflicts) was one of the most frequently mentioned causes of mental health problems by young people in a number of studies
- Divorce and family break up was cited by young people as a source of mental health problems
- Parents who were under stress themselves created further stresses for their children, which impacted in turn on their mental health. Children often tried to help parents relieve their stress but felt ill equipped for the task

- Children exhibited awareness of the broader structural factors that created such stresses for parents and themselves
- At a more severe level, children of parents with a psychiatric disorder reported the way in which concern for parents and the need to adapt their own behaviour to their parent's erratic moods (and also to become carers in some cases) added considerably to their own mental health problems
- Loss, separation or bereavement involving a family member was mentioned in a number of studies as a source of mental health problems by children and young people
- Caring responsibilities for other family members were generally seen by young people as having a detrimental effect on their mental health, making them feel isolated and different from peers, and involving them in constant worry and loss of self-identity
- Abusive relationships with parents (of both an emotional and physical kind) were said to precipitate mental health problems for children and young people

For some young people 'family' is very far from being a refuge and a place of support. Many young people grow up in households that are dysfunctional, chaotic and abusive. Joronen and Astedt-Kurki's (2005) study of the contribution of families to the subjective wellbeing of adolescents (aged 12-16), asked children and young people 'Which familial elements are responsible for adolescent ill-being?'. Family hostility, which included family discord, conflicts and divorce were cited as the most important issue. The young people noted that arguments between themselves and family members were always distressing. Family humour could sometimes be discomforting where it involved joking at the expense of family members. Respondents emphasised that children were adversely affected by strained relationships between parents. Similarly an American study (Ryan-Wenger *et al.,* 2005) which explored stressors in the lives of 7 to 12 year old children in Ohio (N=194) and Washington (N=494), found family disharmony to be important. These researchers compiled a list of the top ten most commonly identified stressors in each sample group. Whilst the data collection methods are different in the two places, so cannot be directly compared, it is notable that family issues feature prominently in these lists. 'Parent mad or yells at me' was cited in both cases, as was 'brother or sister bother me or yells at me'. In Washington 'getting in trouble at home' was also identified as a stressor.

Where adult family members are themselves under stress this could impact on the mental health of children and young people. Brobeck *et al.* (2007) used semi-structured interviews to explore the everyday stresses of 11-12 year olds (N=29). The children and young people reported the stress of their parents, particularly mothers, as having an effect upon their mental health. Stressed parents could impact negatively on relationships within the family, especially if parents were easily angered as a result. The children and young people reported trying to help support parents in these situations, but did not always feel

competent or equipped to do this. Similarly the participants in Johansson *et al.*'s (2007) study reported parental stress as impacting on their own mental health. One 16 year old girl is quoted as saying 'If my mum is having a bad time it is bad for me'. Rather than focusing simply on how bad relationships impacted on their own feelings, the adolescents are reported as commenting on the causes of such poor relationships. These include unemployment and financial circumstances, divorce, and lack of parental time to spend with children. Older respondents also mentioned alcoholism, fighting and illness as unhelpful.

Greater detail of the impact of poor parental mental health on children and young people's own mental health is provided by Riebschleger (2004) who interviewed children and young people aged 5-17 who had at least one parent participating in services at a community mental health agency. The purpose of the study was to 'report a *child's eye view* of living day to day in a family that included a parent with a psychiatric disability' (author's italics). Interview data revealed a pattern of 'good days' and 'bad days' as the parents moved between different phases of their conditions. On good days the children and young people described affection, good communications and interactive activities with parents and linked this to feelings of happiness. These days were contrasted with times when parents were withdrawn (sometimes failing to complete daily tasks such as getting dressed), or were bad tempered, giving rise to feelings in young people of worry, confusion and/or anger. In response to the bad days the children and young people described their own reactive behaviours, mainly ignoring, avoiding or compensation through increasing care-giving behaviours. They also described the longer term concerns these parental behaviours caused them, in terms of possible hospitalisation of parents, or worries about the possibility of suicide of the parent or of marriage breakdown and the implications that this would have on their own future, particularly the likelihood of their being put into care and losing their home. Some respondents worried for their own future mental health, feeling they might inherit or otherwise acquire similar disorders. Others felt they carried some blame for the condition, for example by failing to look after their parents properly, or by causing the illness by their own behaviour.

Death of a family member, was also found be associated with 'ill-being' of children and young people (Joronen and Astedt-Kurki, 2005), although the authors make little comment about this other than it can be depressing or worrying. Ryan-Wenger *et al.* (2005) report that being 'worried about a family member' was also identified as a stressor in the Ohio-based group in their study. Loss of a family member was identified by Scottish young people (White, 2003) as a cause of unhappiness. And grief associated with loss of a loved one (often family) was explored in some detail in the Barnardo's Rollercoaster Service Report (2008). This report (based on a one day activity-based event) focused on young people's accounts of the experience of grief. The report highlights how, for some children and young people, the experience of bereavement can be extremely traumatic. One boy describes the cumulative effect of multiple losses which "pile up to the point where it was too much to deal with, so I stopped

caring". Haydock's (2001) sample of self-harming young people also identify the extreme sadness following a bereavement as the start of some patterns of self-harm.

The impact of family caring responsibilities on children and young people's lives was explored in a British focus group study of 10-16 year old carers (Earley *et al.,* 2007). Four main stressors were identified by the groups. Firstly, they reported feeling different from other children and young people, and noted that this was exacerbated by others' responses to them, including stigmatising, bullying, name calling and general lack of understanding. Secondly, the impact on identity and self-image formed a powerful theme throughout the paper. Children and young people reported feeling engrossed in the role to the exclusion of everything else. When responsibilities were lifted, carers could feel a loss of self, as their self-validation was so closely linked to their caring role. Thoughts about the future were bound up with the responsibilities they were likely to carry into the future, making transitions out of the family difficult to contemplate. Thirdly, the responsibilities carried by the carers required a great deal of vigilance, imposed practical demands on their time, and involved worry about the recipient of care. When absent from the home, for example at school, the carers described a constant worry about whether or not their care recipient would be able to manage in their absence. Finally, the paper comments on the impact of the caring role on relationships. The loss of sense of self is partly ascribed to the scarcity of opportunities to develop relationships outside the family. The young carers could feel resentment of the impact that the role had on current relationships and also concern that future romantic relationships could be impeded by their caring responsibilities. The authors describe a tension between caring and resentment, coupled with a sadness about loss and fears of anticipated loss. On top of the range of stressors that these young people experienced, the stigma of mental health problems led to some families closing in on themselves, keeping the parental difficulties a 'family secret', which were described as a burden carried by the children alone.

Poor family relationships were intricately interwoven with children and young people's accounts of their own mental health difficulties. Farmer's (2002) US study of five adolescents ranging in age from 13 to 17, identified the role that families can play in precipitating or exacerbating depression. These young people reported feelings of 'emotional homelessness', one aspect of which was reported as a feeling of unworthiness in the eyes of family members, and a lack of safety or affection from family relationships. In one case there was an abusive relationship. Perceived lack of trust (of adolescent by parents) and favouring of other siblings were reported to contribute to the isolation felt by the young people. Being caught in the middle of family break-up was also described as contributing to negative feelings, with accounts of feelings of helplessness when watching the disintegration of relationships, often having to align with one parent against the other and watching parents fail repeatedly to make the relationship work.

Furthermore, these findings were echoed by Clark *et al.*'s (2007) study of the subjective quality of life of children with a diagnosed mental health problem. Accounts of chaotic family relationships, with mention of fighting between parents and step-parents, fights with siblings and separation from parents and siblings were deemed by children and young people to be detrimental to their quality of life. Linked to this were issues of grief and loss.

That unhappy family relationships are intricately linked to poor mental health was also confirmed by an internet study of adolescent self-harmers (Murray *et al.,* 2005). Whilst this study was largely concerned with exploring the profile of self-harmers, rather than identifying the reasons for the self-harm, it was revealed that 89.1% of the respondents (N=128) indicated that they had self-injured in response to 'difficult family relationships'. This is confirmed by the study of self-harm commissioned by Penumbra (Haydock, 2001). Four out of ten children and young people (aged 16-21) stated in interviews that they had self-harmed in response to family break-up. Two had self-harmed as a response to bereavement, but the study does not comment on whether this refers to a family member.

Over-dependence on parents was identified by children and young people in one study as a source of 'ill-being' (Joronen and Astedt-Kurki, 2005). The older participants in the study expressed a desire to become more independent from their parents. However, apart from this brief mention, this topic does not receive other attention in this literature.

4.5 The impact of school and peer relationships on children and young people's mental health

In this section we have included reports about peer interactions. Peers are not the same as friends. The peer group is the age and social reference group against which young people tend to compare themselves, and as such, is often located at school and in interactions with school mates. Not all of these by any means would be classed by young people as falling within the category of 'friends', the impact of whom on mental health is dealt with separately.

4.5.1 Positive impacts of school and peer relationships on mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Gallichan & Curle	2008	10-17, N=12. England	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Lee & Breen	2007	16-17, N=12,	++

		Australia	
Sixsmith *et al.*	2007	8-12, N=24, Ireland	++

- School was often not mentioned in general accounts by young people about mental health
- Where school was mentioned by children and young people it was relationships at school, both positive and negative, which were the main focus of accounts
- School environment was mentioned in one study with children and young people expressing a preference for well maintained buildings which allowed places for young people to meet and talk
- Friendships and interaction with peers was seen as one of the most important aspects of school which contribute to mental wellbeing
- Relationships with teachers are also noted as important, the best being where teachers are respectful, kind and patient
- The development by schools of individualised support from teachers when children and young people are facing difficulties was seen as critically important in promoting mental wellbeing by those facing specific problems

In general studies of children and young people's views, the links between mental health and school are not often made, which some might consider surprising, given the amount of children and young people's time that is spent in school. For the 8-12 year olds in Sixsmith *et al.'s* (2007) study, school was depicted in their schematic diagram as being a very low priority in their list of factors that affect wellbeing. In a complex diagram which includes 24 categories, only 'flowers' and 'clock' are lower down the pecking order than school. Whether this should be interpreted as school being unimportant, or simply taken for granted, or whether it indicates an active dislike of school is not clear. However, an arrow links 'school' directly to the category of 'soccer and sports' which is of high importance, just marginally less so than 'family'. Clearly, for these children, some aspects of school are important to wellbeing.

School does, of course, provide an arena for personal achievement, whether in the academic or sporting sphere, as discussed already in section 4.3.1, and even young people sampled deliberately for their poor school experiences in Lee and Breen's (2007) study of excluded and disaffected pupils noted that they could recall positive school experiences, such as being asked to play for the school basketball team.

Johansson *et al.* (2007) note that when adolescents talked about school being an important part of their lives, they mainly talked about friends and teachers, so again, it is the relationships which seem most dominant for young people. Environment is mentioned briefly in this study, however, with both girls and boys mentioning that the school building should be a nice place to be in, tidy and

clean. This could influence your mental health, according to the children. There should not be broken things at school, according to boys in this study. Good food was mentioned and also places where children could sit and talk.

The importance of relationships within schools and within other settings is a repeating theme in the literature. Johansson *et al.*'s (2007) Swedish study of adolescent girls' and boys' perceptions of mental health found that when their respondents spoke of the relevance of school to mental health they focussed on their relationships with people in the school setting. Friendships with peers were seen as the most important aspect of school, with relationships with teachers coming second. Lee and Breen's (2007) young participants also note that socialising with peers was the most important part of school for them, particularly interactions on a practical, non-academic level. The school environment was useful for the development of social skills and networks even if, for this group of youngsters in particular, the school environment was not conducive to their other needs.

Good teachers in the Johansson *et al.*'s (2007) study were described as possessing such attributes as kindness, patience, or as being helpful and caring. Good teachers were characterised by their relationships with pupils, rather than by their knowledge or teaching skills. They should, it was suggested by children and young people, be sociable, not too task-orientated and capable of maintaining order. Mutual respect was seen to be important.

For children and young people facing specific difficulties such as those with ADHD in Gallichan and Curle's (2008) study, the quality of relationships with school staff was critical to their sense of self. From interviews with children and young people the authors identified a 'virtuous circle' whereby schools which were prepared to develop strategies to meet the individual needs of the children, enhanced their sense of mental wellbeing and their feeling of being in control of their own behaviour. Whether ADHD was deemed to be problematic in the school setting hinged upon the relationships between the child and the teachers, which, in turn, impacted upon relationships with other children.

4.5.2 Negative impacts of school and peer relationships on mental health

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Bourke & Geldens	2007	16-24, N=91, Australia	++
Brobeck *et al.*	2007	11-12, N=29, Sweden	++
Clark *et al.*	2007	5-18, N=53, USA	+
Gallichan & Curle	2008	10-17, N=12,	++

		England	
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Lee & Breen	2007	16-17, N=12, Australia	++
Lynch & Spence	2007	16-21, N=4, New Zealand	++
McCaffrey	2006	5-15, N=6, Australia	+
Ryan-Wegner *et al.*	2005	7-12, study 1 N=194, study 2 N=494, USA	++
'Grey'			
Girlguiding UK	2008	10-14, N=404, England	+
Haydock	2001	16-21, N=46, Scotland	++

- Poor school environments were said by young people in one study to affect the way they felt about school, with schools being likened to prisons and cages
- Stress related to pressures of school work affected many children and young people
- These pressures related both to the pressure to succeed, but also to time pressures and needing to fit everything in to an increasingly busy schedule
- Poor relationships with peers at school were a source of mental health problems identified by children and young people, particularly where bullying and gossip was involved
- Poor relationships with teachers were equally problematic
- Lack of understanding and failure to be offered specific supports when facing difficulties outside of the 'norm' such as chronic illness also caused problems severe enough to cause school withdrawal.

Some young people found aspects of the school environment very daunting. Lee and Breen's (2007) young subjects noted that the way the school looked affected the way they felt about going there. Some students claimed that their school looked like a prison, and another noted that 'we are caged in like animals' The participants felt that they were not trusted or considered responsible because wire fences surrounded some of the schools.

A repeating theme in children and young people's accounts in the literature was that of the pressures created by the demands of school work. Girlguiding UK (2008) noted young girls and women reporting that academic pressures caused them to feel anxious and nervous. In particular shortage of time was seen as a major stressor, with children and young people feeling under pressure to fit

everything into their lives, this being linked to pressure to achieve. Bourke and Geldens' (2007) respondents also spoke of 'juggling' and 'balancing' a lot of activities, and the importance of 'coping' with this. Significant pressure was related to achieving.

Brobeck *et al.* (2007), in their study of pupils' experience of stress in everyday life, also identified time pressure, within school and out of school, as highly significant. Feelings of 'falling behind' with class work or having too many things to do were identified as stressful. Failure to keep up with the pace of classmates led to feelings of inferiority. Lack of time to complete work also led children and young people to fear producing unsatisfactory results. Respondents also commented that having too many lessons on the same day was overwhelming, particularly if each lesson generated homework, which in turn led to stressful evenings trying to address all the requirements.

Brobeck *et al.'s* respondents, uniquely amongst these studies, identified a school-related time issue, a fear of being late. Being late for school (or worry that you might be) was identified as stressful, as was being late for class. Possibly this was an issue related to fear of school discipline, although the study does not state this to be the case.

Ryan-Wenger *et al.'s* (2005) US study of changes in stressors over the past 30 years note that the identification of time pressure is a new phenomenon. In the literature review which prefaces their work they comment on the fact that studies conducted with children and young people in the 1990s and earlier make no mention of this type of stress in children, but by comparison their own 2005 study identified homework (too much), homework (in general) and 'too many things to do' as significant sources of stress. The authors ascribe this to performance-related pressures on schools, and to the trend for parents to organise more leisure activities for their children.

In the same way that positive relationships in school were identified as contributory to mental wellbeing, so poor relationships were linked to mental health problems. Children and young people in Johansson *et al.*'s (2007) study pointed out that relationships in school could be negative as well as positive. For this group the notion of bullying was something associated mainly with school.

Clark *et al.*'s (2007) study is limited methodologically: the age range is very wide (5-18), interviews were extremely brief (10-20 minutes) and only one instrument was used. Nevertheless the accounts given by children and young people shed some light on how children diagnosed with a mental health problem experience peer relationships. It is included in this section because a desire for acceptance by others was described as so important by these young people. This desire for acceptance was often described alongside reports about peers who did not accept them and who bullied and described them as crazy: For these young people becoming 'normal' was a goal. Factors described as being normal

included being medicine free, having a consistent presence of supportive adults and ‘fitting in’.

Equally, relationships were seen to be the most important factor for young people who described difficulties at school. In a sample of Australian young people who left school early (Lee and Breen, 2007), the decision to do so was universally linked to experiences of poor relationships within the school. Some had been explicitly excluded, but many, Lee and Breen reported, were subject to ‘implicit exclusion’ through being marginalised by peers. Bullying and gossip were commonly cited when young people were asked what they disliked about school. One student in this sample commented, “..most people in my year would give me a hard time”, and another noted that she was “the little odd person that nobody liked…I was afraid of what my peers would say or do so I would come late to school.”. Haydock’s (2001) report on self-harmers for Penumbra cites some respondents identifying their self-harming as a result of feelings being linked to bullying from peers.

For children and young people with particular needs, relationships within school could be crucial to mental wellbeing. McCaffrey (2006) reports in some detail the harrowing experiences of young cancer suffers when they return to school, and this was described by participants as being detrimental to their self-esteem. Other children were reported as being very hurtful, through teasing and bullying behaviours.

As well as relationships with peers, relationships with teachers are equally important to children and young people. In Lee and Breen’s study (2007) children and young people talked about being treated disrespectfully or unfairly by teachers. All twelve participants felt they had been subject to unfair treatment by the school. They discussed teachers who had favourites or who predicted failure for them, and how such attitudes encouraged disengagement.

Young people with ADHD in Gallichan and Curle’s (2008) study who described the value of positive relationships with staff (above) also offered accounts of the impact of teachers who failed to take account of their needs. The judgements made of them by teachers and peers could result in reactions (such as anger) which exacerbated the sense of difference and fulfilled the expectations of others, thereby giving rise to a vicious cycle.

In McCaffrey’s study of young cancer sufferers some young people returning to school found staff were equally unhelpful, being unprepared for the needs of these children, and at times unsympathetic. In some cases these issues were so severe that children moved schools or withdrew from schools as a result. The author notes that the transition between hospital and school was very difficult for these young people, as the school community was unprepared, or possibly unwilling, to support such children. Similarly Lynch and Spence (2007) report the school experience as contributing to the stress experienced by sufferers of

Crohn’s disease. Absence of support and a lack of understanding led one of their study participants to fall behind with school work, and ultimately leave school to find work.

4.6 The pivotal role of friendships on children and young people’s mental health

4.6.1 Positive impacts of friendships on children and young people’s mental health

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Ellis	1999	14-15, N=24, New Zealand	++
Farmer	2002	13-17, N= 5, USA	++
Hetherington & Stoppard	2002	14-17, N=14, Canada	++
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Lynch & Spence	2007	16-21, N=4, New Zealand	++
Sixsmith *et al.*	2007	8-12, N=24, Ireland	++
Woodgate	2005	12-18, N=15, Canada	+
‘Grey’			
Girlguiding UK	2007	5-25, N=3242, England	+
Girlguiding UK	2008	10-14, N=404, England	+
Haydock	2001	16-21, N=46, Scotland	++

- A recurring theme in the literature was the importance of friendships to mental wellbeing
- Important features of friendship included trustworthiness, talking and listening, sharing of problems
- The positive impact that the support of good friends could have through difficult times was identified repeatedly by children and young people

- For troubled adolescents, fending off depression involved coping strategies based on talking to reliable, knowledgeable and trusted friends.

The importance of close friendships to mental wellbeing was a recurring theme (Johansson *et al.,* 2007). A report by Girlguiding UK (2008) notes young women's feelings that happiness goes hand in hand with good friendships. Friends were often used to check out whether feelings were 'normal' or symptomatic of more serious difficulty. Isolation from friends and withdrawal from networks were often described by children and young people as signs that something was wrong with an individual.

Sixsmith *et al.* (2007) invited groups of children, parents and teachers in Southern Ireland to construct categories of wellbeing in an innovative study using photography. Children located family higher than friends in a hierarchy of relationships important for mental wellbeing. However, children took more photographs of friends than of any other category. Interestingly, pets were also given a more prominent place by the children than by either parents or teachers. Overall, the children made more linkages between components than parents and teachers, reinforcing findings from elsewhere that children and young people view mental wellbeing as a holistic concept.

Of the young women who participated in the national study undertaken by Girlguiding UK (2007), 89% reported having good friends as the greatest influence on how girls feel about themselves.

The important features of friendships were consistent throughout the studies. Friends were people who could be trusted and people that you could talk to (Johansson *et al.,* 2007). The children and young people in Armstrong *et al.*'s (2000) study identified friends as people who could share problems, although it was notable that young people from Muslim/Pakistani backgrounds felt that such conversations should be restricted to their extended families. The 8-12 year olds in Sixsmith *et al.*'s (2007) study linked friendship to 'fun' in their schematic diagram. Ellis's (1999) New Zealand study highlighted the link between positive experiences of friendship and self-esteem.

The positive impact that the support of good friends could have through difficult times was identified repeatedly by children and young people who were coping both with normal adolescent problems (Armstrong *et al.,* 2000) or with particularly difficult circumstances such as chronic physical illness or a diagnosed mental health problem (Lynch and Spence, 2007; Woodgate, 2005; Farmer, 2002). Farmer's study, for instance, involved a very small sample of five depressed adolescents in the USA. Whilst the fickleness of friends could be a source of very real trauma for some depressed adolescents, other young people in the same studies described friends as numerous, loyal and helpful, and as having played a major part in helping them through depression. Friends were the ones

who noticed first that their mood was sliding downwards and could encourage them to talk about their problems and get them out in the open.

Hetherington and Stoppard (2002) undertook a Canadian study with 14 adolescent girls aged 14-17 to investigate their understanding of depression through a series of individual interviews. Participants reported that maintaining social connections was fundamental to fending off depression and coping strategies were based on talking to reliable, knowledgeable and trusted friends. However, adolescent girls highlighted a need to be selective about which friends were used in this capacity. The best qualities in a good friend included being someone who listened rather than talked, having a professional background or having experience of depression themselves and being prepared to 'share the burden'. Similarly Haydock (2001) notes self-harmers identifying the importance of friendships in preventing self-harm.

4.6.2 Negative impacts of friendships on children and young people's mental health

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Earley *et al.*	2007	10-16, N=17, Ireland	++
Ellis	1999	14-15, N=24, New Zealand	++
Farmer	2002	13-17, N= 5, USA	++
Gallichan & Curle	2008	10-17, N=12, England	++
Hetherington & Stoppard	2002	14-17, N=14, Canada	++
Kendall *et al.*	2003	6-17, N=39, USA	++
Lee & Breen	2007	16-17, N=12, Australia	++
McCaffrey	2006	5-15, N=6, Australia	+
Riebschleger	2004	5-17, N=22, USA	+
Stanley	2007	12-19, N=14, UK	+
Whitehead	2000	16-19, N=95, England	+
Wisdom & Green	2004	14-19, N=22, USA	++
'Grey'			
Girlguiding UK	2007	5-25, N=3242, England	+

- The withdrawal of friendship through 'falling out' and argument was described as traumatic by young people
- Rejection by or isolation from friends and peers was seen as directly affecting children and young people's mental health
- Mental health problems experienced by children and young people could in themselves cause estrangement from friends
- Similar estrangement from friends and peers was experienced by other young people who fell outside the norm as a consequence of their own physical health problems or the health problems of parents where children had a caring role
- Looked after children and young people who moved into and out of care or between placements found it equally difficult to sustain friendships, and they and young carers felt that their specific life experiences estranged them from friends who did not understand what they endured
- Life transitions such as leaving school or becoming pregnant disrupted friendships.

Whilst friendship is clearly an important factor in mental wellbeing, unkindness delivered by friends was viewed as having negative impacts by young people. Young women reported feeling 'hurt' when friendships broke down, citing arguments and 'fall-outs' with friends as being emotionally 'difficult' (Girlguiding UK, 2007). The damage that derogation, put-downs and 'being hassled' could do to self-esteem was identified in Ellis's study (1999).

Rejection by friends and peers is a theme which runs through the literature. Farmer's (2002) small sample of depressed young people reported that unreliable friends and friends who rejected or excluded them could trigger isolation and depression.

However, mental health problems could in themselves cause rejection, a fact which was evident in many papers, leading some children and young people to lose touch with many friends and thereby changing their relationship to the wider community (McCaffrey, 2006; Hetherington and Stoppard, 2002). But rejection by friends was a common complaint of many young people who fell outside the norm, such as looked after children and young people. Stanley (2007), for instance, reports that being 'in care' separated them from their peers and friends and rendered their experiences intelligible only to those with lived experience of the system. Young carers (Earley *et al*., 2007), those with ADHD (Gallichan and Curle, 2008; Kendall *et al.,* 2003), and those whose parents had a mental health problem (Riebschleger, 2004) reported similar problems.

Disruption to friendship networks was a feature of the lives of children and young people who left school early (Lee and Breen, 2007). The respondents in this study expressed surprise and disappointment at the loss of friendships at this point of transition. Subsequently their social networks revolved around colleagues, housemates and boyfriends/girlfriends. Equally the disrupted lives

experienced by looked after children and young people afforded them little control over the sustainability of their friendships, and added to the sense of instability within their lives (Stanley, 2007). Similarly Whitehead (2000) describes how pregnancy can impact on the mental health of young women (aged 16-19), through the loss of friendship and 'social death'.

The death of a friend was also identified as a specific life event which some participants in the study by Wisdom and Green (2004) of young people diagnosed with depression, experienced as having a negative impact on mental health.

4.7 The role of relationships with other adults on children and young people's mental health

4.7.1 Positive impact of relationships with other adults on children and young people's mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Secker *et al.*	1999	Not recorded, N=120, Scotland	++
Sixsmith *et al.*	2007	8-12, N=24, Ireland	++
Stanley	2007	12-19, N=14, UK	+
Woodgate	2006	13-18, N=14, Canada	++

- Adults outside the family were rarely referred to by children and young people as sources of mental wellbeing support except professionals that they were in contact with (teachers, social workers etc)
- Children and young people described the value of 'having an adult to talk to', but noted that choosing the right adult in whom to confide involved judgement on their part
- Relationships with other adults were described as having most value when adults were respectful, non-judgemental, trustworthy and sincere in their interactions
- Where troubled children were in receipt of services they valued adults who treated them holistically and expressed faith in them and a desire to see treatment through to the end
- Support from adults who had 'been there themselves' was seen as particularly important by looked after children

- Young people saw as important their freedom to choose whether to participate in counselling or therapeutic support, and when (or whether) to disclose information

In Sixsmith *et al.'s* (2007) innovative study where children used photography and constructed categories of wellbeing, children gave neighbours a high priority, but generally, there was little mention of relationships with adults outside the family, with the exception of professionals (teachers, social workers, therapists etc) whose roles were linked to the welfare of children and young people.

Two linked studies (Armstrong *et al.*, 2000; Secker *et al.*, 1999) found that young people felt that being able to talk to an adult – not always a parent - could be valuable in helping to maintain mental wellbeing, but young people noted that selection of an adult confidante involved careful assessment. Trust and confidentiality were important attributes of helpful support, as was empathy in recognising the issues that were salient to young people. Young people felt that some adults could only be helpful confidantes within a narrow range of topics. Teachers, for example, could be important in helping with troubles, but only in relation to school-based issues.

For young people already experiencing difficulties in relation to their mental health, the success or failure of relationships with other adults will shape their experience of support, and hence will impact upon their mental health. Interviewees in the studies were forthcoming in their views of what made for successful adult support. Adolescents with experience of depression participating in Woodgate's (2006) Canadian study, for example, described how they felt valued by healthcare professionals who respected them and were perceived to be sincere in their interactions. Lack of respect or understanding only resulted in adolescents not wanting to continue with their treatment. They felt valued by health care professionals who were focused on children and young people holistically, and not simply on the illness or symptoms. Those adults who were flexible in their approach and did not give up on the children and young people were also valued. Adolescents valued healthcare professionals who were focused on getting them better and, despite setbacks, never would give up on them. Young people recorded how frightening and painful it was to feel that a professional no longer cared for them.

Stanley's (2007) study highlights the value placed by young people on having mentoring support from adults who had themselves experienced the care system. The author suggests that such 'positive models of survival' are found by young people to be 'authentic and encouraging'.

For looked after adolescents, choice and control in seeking support was a key aspect to the way in which it was subsequently viewed (Stanley, 2007). Freedom to choose whether to participate in counselling or therapeutic support, and when to disclose information were seen as important for their mental health. They also

described availability and continuity of staff as key issues in promoting their mental wellbeing.

4.7.2 Negative impact of relationships with other adults on children and young people's mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Shelton	2004	13-17, N=30, USA	+
Stanley	2007	12-19, N=14, UK	+
Woodgate	2006	13-18, N=14, Canada	++
'Grey'			
Haydock	2001	16-21, N=46, Scotland	++
White	2003	9-24, N=77, Scotland	++

- Relationships with other adults were fraught with difficulties over the extent to which disclosures could be treated as confidential by adults
- Access to therapeutic adult professionals were felt to be very necessary by some young people, but was often felt to be stigmatising
- Young people often did not know how to access services or felt that they would only be referred or receive treatment and support when problems had escalated to a very serious level
- Working with adults outside the family was not seen by children and young people as beneficial when those people were:
    - overly controlling
    - dismissive of children and young people's accounts
    - blaming
    - over-keen to medicate
- Young people in care found it difficult to form relationships with other adults working with them because of constant staff turnover and patterns of shift working

Young people in Armstrong *et al.'s* Scottish study (2000) felt that it was important to have adults other than parents to talk to, but many were unsure who could fill this role. Many felt there were no professionals they could really trust, and confidentiality was a further issue expressed by young people. While they accepted, at least to some extent, that teachers and other professionals had a duty to pass on information if they thought it necessary, they were concerned that this restriction on confidentiality was not always clear to begin with.

Equally, relationships with other adults or therapeutic professionals could at times be problematic. For example, being seen by others to even contact a professional, for example a counsellor, could reinforce existing problems by stigmatising the young person. This point was strongly reinforced in Shelton's (2004) study of minority young people with diagnosed mental health problems who were detained: the researcher interpreted a conflicting desire to 'talk to someone', but a fear of this being made public.

For those young people for whom professional support was a regular feature of their lives, an ambivalence was expressed about the quality and usefulness of such relationships. As described above, issues of trust and confidentiality were paramount in determining how they engaged with the supports available.

In Scotland, White (2003) identified serious shortcomings in the support services available for mental health problems. Knowledge of how to access support was poor amongst young people and access was difficult, with long waiting lists. Young people commented that until problems progressed to a serious level, it was difficult to see professionals.

Within the Penumbra study of self-harm in Scotland (Haydock, 2001), impressions of services were mixed, with the benefits derived being linked to the personal qualities of individual professionals. Poor experiences were linked to people who were blaming in their approach, dismissive of children and young people's views, too keen to medicate and who failed to consult young people's own wishes. The children and young people in this study also reported that they would withdraw themselves from professional relationships which were too controlling. Similarly, as reported above, Woodgate's (2006) respondents indicated that lack of respect and understanding or adults who were judgemental could result in children and young people withdrawing from their treatment.

Stanley (2007) investigated the views of 14 looked after young people aged 12-19 and found that aspects of their experience of being looked after contributed to their mental health. Four single sex focus groups explored a range of questions using a range of trigger materials. The participants were recruited from residential homes, foster care settings and a leaving care project. As well as describing availability and continuity of staff as key issues in promoting their mental wellbeing they also reported that this was highly problematic with shift working, changing placements and turnover of staff.

4.8 The impact of neighbourhoods and communities on children and young people's mental health

4.8.1 Ways in which neighbourhoods and communities impact positively on children and young people's mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Secker *et al.*	1999	Not recorded, N=120, Scotland	++
'Grey'			
Barnardo's	2008	10-17, N=69, Scotland	+
Girlguiding UK	2007	5-25, N=3242, England	+
White	2003	9-24, N=77, Scotland	++

- Community settings which offered plenty of activities for children and young people were seen as promoting mental wellbeing
- Sport was particularly mentioned as promoting feelings of happiness
- One study highlighted the importance for mental wellbeing of activities which allowed young people to be of service to others
- Unpressured space for young people to meet and interact was seen as essential by young people. One study suggested that girls and young women needed single sex environments in which to do this as well as mixed ones.

In a pair of linked Scottish studies (Armstrong *et al.*, 2000; Secker *et al.*, 1999) children and young people identified the positive impacts on mental health of activities available in the communities. However, the provision of leisure activities within the community was highlighted much more in the 'grey' literature. Things to do, places to go and money with which to access them were identified in consultation for the SNAP report (White, 2003). In this report children and young people highlighted the value of sport for mental wellbeing, in terms both of addressing boredom, and as promoting feelings of happiness in its own right. Sport was also identified as a source of happiness by children and young people in the Barnardo's Roller Coaster study (2008).

Girlguiding UK (2007) identified the value of clubs and activities as providing sport and other activities and new experiences. These were described by the young women interviewed as making them feel 'good about themselves'. This

report was alone in identifying 'helping other people' as an activity that promoted mental wellbeing, perhaps not surprising given the ethic of the organisation. In addition the girls interviewed as part of this study felt that such activities offered unpressured environments where friends could socialise. In particular, for girls, single sex activities allowed them to relax in a non-sexualised environment.

4.8.2 Ways in which neighbourhoods and communities impact negatively on children and young people's mental health

Author	Year	Age range, sample size, country	Quality rating
Peer-reviewed			
Armstrong *et al.*	2000	12-14, N=145, Scotland	++
Ryan-Wegner *et al.*	2005	7-12, study 1 N=194, study 2 N=494, USA	++
Secker *et al.*	1999	Not recorded, N=120, Scotland	++
'Grey'			
Girlguiding UK	2007	5-25, N=3242, England	+
Haydock	2001	16-21, N=46, Scotland	++
White	2003	9-24, N=77, Scotland	++

- Community settings which offered few opportunities for activities were seen as encouraging boredom which was itself seen as bad for mental wellbeing
- Children and young people from rural areas and areas of deprivation were most likely to cite the lack of activities in their area as bad for their mental health
- Young people living in communities where drugs are in widespread use noted these as being potentially injurious to their mental health
- Violence in some communities was suggested in one study as a negative factor for mental health.

Just as young people identified the importance of activities within the community for mental wellbeing, the absence of activities or the presence of some more damaging opportunities got a brief mention in the literature. In a pair of linked Scottish studies (Armstrong *et al.*, 2000; Secker *et al.*, 1999) children and young people identified the feelings of 'boredom' that could result from 'nothing to do and nowhere to go'. There were differences between young people in the four schools used as settings for the study. All the young people interviewed

individually in schools from the most deprived area and the rural area quickly identified boredom as a major influence on mental health, as did the group discussions. These feelings were far less prominent among young people in the suburban schools and the minority ethnic sample. More of these young people appeared to be involved in activities outside school. In turn, the authors note, this may reflect differences in location and class between the schools.

The wide ranging consultation exercise with children and young people undertaken as part of the SNAP report (White, 2003) also identified unhappiness linked to boredom. This was described as having nowhere to go, nothing to do and no money. With a nod to issues of rurality, boredom was also linked to 'living in the middle of nowhere'. Similarly, Girlguiding UK (2007) identified that boredom could give rise to negative feelings which could in turn result in 'trouble'.

Scottish studies make brief reference to easy access to drugs being viewed as potentially hazardous to mental wellbeing in some communities (White, 2003), and to the self-destructive use of drugs being a form of self-harm (Haydock, 2001) However, the young people who participated in the SNAP report consultation (White, 2003) demonstrated mixed feelings toward drugs, as a table with columns for items that promote happiness, against items that give rise to unhappiness listed 'recreational drugs' in both columns.

There is a hint that neighbourhoods may not always be safe. Ryan-Wenger *et al.* (2005) identifies 'violence in my school or neighbourhood' as a stressor emerging in the 1990s in the USA.

4.9 The impact of structural factors on children and young people's mental health

4.9.1 Positive impact of structural factors on children and young people's mental health

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Bourke & Geldens	2007	16-24, N=91, Australia	++

- In most instances children and young people do not refer directly in their own words to structural issues such as poverty, race and gender as lying behind some of the more immediate and personal issues that beset them and impact on their mental health

- Appropriate support from service agencies delivering good housing for example was acknowledged by young people in one study as contributing to their mental wellbeing

Most studies reviewed here were about individual experiences of mental health issues. Therefore, little attempt is made to explore how structural factors such as poverty, inequality, race and gender interact with individual and family factors in mental health and the accounts given by children and young people across the papers make little direct reference to these issues. Yet the links between health, education and poverty are well known, and it is likely that many of the issues that children and young people experience as relationship issues are underpinned by wider structural issues. In particular where papers talk about rejection, stigmatisation, exclusion and so on, it seems probable that these would be linked in some cases to poor access to resources.

One exception to the silence is Bourke and Geldens' (2007) Australian paper which compares the views of school- aged children and young people with those of 'service users' (aged 16-24). Whilst the school aged children and young people tended to conceptualise subjective wellbeing in terms of personal goals and achievements, the service users were reported to be more likely to cite structural issues such as support from services, housing and employment as contributing to subjective wellbeing. The service users were outside of education and, in many cases independent from parents, so in this case they would have direct experience of having responsibility for earning money, organising accommodation and seeking support with those processes.

4.9.2 Negative impact of structural factors on children and young people's mental health

Author	**Year**	**Age range, sample size, country**	**Quality rating**
Peer-reviewed			
Johansson *et al.*	2007	13-16, N=48, Sweden	++
Kendall *et al.*	2003	6-17, N=39, USA	++
Riebschleger	2004	5-17, N=22, USA	+
van Daalen-Smith	2008	14-24, N=65, Canada	+
'Grey'			
Girlguiding UK	2008	10-14, N=404, England	+
Haydock	2001	16-21, N=46, Scotland	++
White	2003	9-24, N=77, Scotland	++

- Young people living outwith the support of their family are more likely to evidence factors such as employment, poverty and housing as factors critical to mental health
- Young people caring for parents with a mental health problem appeared to be the most acutely aware of the extent to which structural factors like poverty created the stressors that exacerbated their parent's condition
- Only one study specifically mentions young people's understandings of ethnicity/racial discrimination as a factor undermining mental health
- Young people acknowledge that boys and girls vent their frustrations and express themselves differently, with girls often feeling obliged to suppress negative expressions of emotion because of gender stereotypes
- Girls also saw themselves as under double pressure to conform to idealised views of what women should look like and how they should behave.

The impact of unemployment or money problems on family life was briefly mentioned in Johansson *et al.*'s (2007) paper, which looked at familial aspects of subjective wellbeing. However, the most overt reference to poverty was made by Riebschleger (2004), who reported that her participants often said that their parent's mental health problem was merely a part of a number of problems in their lives. Children and young people described feeling worried about the family not being able to meet financial commitments, and over their instability of housing. The exclusionary impact of poverty was also raised in this paper, with children and young people reporting teasing and name calling in relation to being perceived as a 'poor kid'.

Homelessness was mentioned in two cases in the 'grey' literature emanating from Scotland, although little detail was provided. Two individuals reported that they had self-harmed as a result of homelessness (Haydock, 2001). The lack of personal space that accompanies homelessness was identified as a 'difficulty' by respondents in the consultation for the SNAP report (White, 2003).

A hint of the interconnection between migration and other structural issues was detectable in Kendall *et al.*'s (2003) interview study of 39 children and young people with ADHD, 13 of whom were Hispanic and 15 were African American. One Hispanic interviewee commented "I'm not discriminated against, but we are different from White America." Later, the same girl followed with, "We come from over there and we have to learn the language, to learn English and it is just more difficult for us. And we don't have the money for everything we need".

There are gender differences in the ways in which boys and girls experience life, and of course mental health, which also thread through the accounts. As pointed out earlier, whereas boys valued personal achievement often in relation to sport as contributing to feelings of mental wellbeing, girls laid more emphasis on body image and keeping fit. Girls were much more likely to attach great importance to

relationships and friendships, and self-confidence could be badly shaken by their rejection by friends or a boyfriend and was linked by them to depression (Haydock, 2001; Johansson *et al.*, 2007).

Whilst some boys felt under pressure to conform to dominant images of masculinity which led them to suppress feelings of vulnerability or distress, girls equally came under pressure not to express anger. Expressing anger was viewed as leading to disapproval or punishment for girls and some felt that the repression of these feelings disconnected them from their emotions (van Daalen-Smith, 2008). However, it was also reported as alerting others to the seriousness of the condition. For these reasons, expressions of anger were viewed by children and young people as potentially both positive and negative.

Girlguiding UK (2008) identifies the 'premature sexualisation and pressure to grow up too quickly' as two of the 'key influences on girls' mental health, as already noted in the section on 'self'. Sexual advances, pressure to wear clothes which make them look older than their years, magazines that emphasised physical appearance and weight were all identified as taking a 'particular toll'. The report suggests that girls felt that the 'checklist of ideals' against which they were judged provided ammunition to bullies to single out girls and young women.

5 Discussion

In this section we discuss briefly some of the more cross-cutting themes that emerged from the literature review, establish the limitations of the review and undertake a brief comparison with the previous review of Harden *et al.* (2001), before attempting to summarise in tabular form the factors that children and young people see as having a positive and negative impact on their mental health Finally, we assess the implications of the findings for the mental health indicators framework for children and young people.

5.1 Children and young people's holistic view of mental health

Whilst individual factors are reported to be important to young people's mental health, these are set within wider social contexts of family, school and community. One clear example of this is the work by Bourke and Geldens (2007). Whilst the children and young people in this Australian study were reported to focus mainly on personal assessments and emotions when talking about their subjective wellbeing, the authors noted that these were related to family environments, school achievements, friendships, employment prospects and broader opportunities. Thus, they commented that "environments were key to shaping their (children and young people's) relationships, emotions, goals and actions that they believed were key to their wellbeing" (p 183).

Children and young people generally took a holistic approach to mental health, stressing the ways in which different aspects of their lives worked together to influence it. They emphasised the interaction between feeling happy and how this was reinforced by approval from others in their social networks, doing well in school and being liked by others. Individual stressors and day-to-day anxieties were viewed as part and parcel of growing up and young people generally felt that, given adequate support, they could deal with these. The converse was equally evident: social isolation, combined with difficult interaction with peers, family and teachers could trigger negative feelings and in turn could exacerbate feelings of poor self-worth and fitting in. It was the accumulation of stressors, rather than single factors, which young people described as being injurious to mental health, a fact which is inevitably rather lost in the summary table below (Table 2, Influences on children and young people's mental health). The study by Riebschleger (2004) of young people living with a parent with a mental health problem provides a good illustration of how different factors overlap in the mental health of children and young people themselves. The concerns that the young people expressed were not simply related to the mental health problem of their parents. The author reported that 'most' families were in receipt of Medicaid, indicating a low level of family income. Concerns about poverty, and the stigma associated with poverty were voiced by these young people. Housing instability was an additional feature of their lives. The young people were also concerned about parental divorce and relationships within the family. Poverty and concerns about parental divorce were reported to be more worrisome to the children and

young people than the parents' mental health problem. On top of the range of stressors that these young people experienced, the stigma of mental health problems led to some families closing in on themselves, keeping the parental difficulties a 'family secret', which were described as a burden carried by the children alone.

There was a consensus across studies that social relationships were a source of both strength and problems, the latter undermining mental health. Thus, Farmer's (2002) small sample of depressed young people reported both that loyal and helpful friends who noticed when something was wrong and who talked about the depression provided an important resource, while unreliable friends and friends who rejected or excluded them could trigger isolation and depression. Good relationships with family (including extended family), friends and pets were viewed as important components of mental wellbeing. Linkages and interconnections between different parts of these networks were reported by children and young people as significant, though it is hard to bring this aspect out in the account here.

The need to feel 'normal' is a thread running through many accounts, a factor which increases with the age of the young person as the peer group becomes more and more important to them. A lot of effort at this life stage goes into being 'like everybody else'. This is what makes some of the studies that deal with young people in abnormal situations so interesting, as it is their deviance from the normal state and the sense of isolation which this produces in them which is clearly injurious to mental wellbeing. McCaffrey's (2006) Australian study of children with cancer, for example, found a range of issues to be salient. Although the sample of children was small (6 children) and covered a wide age range (5-15 years), the findings echo those of earlier studies. Just as difficult and damaging to mental health were relationship issues, such as dealing with the ignorance of others on return to school (including coping with bullying and harassment), being unable to participate in sports and feelings of physical and social isolation which they related to uneven attendance at school and the fracturing of friendships.

5.2 Transitions

Change of context and setting or environment could provide both positive and negative triggers in relation to mental health. For young people experiencing physical illness, for example, transitions from school to hospital often provoked anxiety, stress and fear. The unpredictability of such transitions often disrupted relationships and reinforced feelings of difference and isolation as participants in Woodgate's (2005) study clearly articulated. On the other hand, children with attention deficit hyperactivity disorder (ADHD) who moved to smaller education units also reported to researchers that - despite initial anxiety - they felt safer, more able to deal with their condition and could marshal more support, having made the transition from mainstream schools.

The transitions of young people who moved through or into a different life phase also posed challenges to mental health. Lee and Breen (2007), for example, researched the perceptions of Australian young people who had left school early. On the whole many who had made a successful transition into employment experienced this in a positive way, and felt that they were treated with respect and as an equal by workmates. They contrasted this with previous negative school experiences where some had felt bullied and excluded. On the other hand the jolt on leaving school of discovering that this fractured friendships and caused a loss of support networks was noted by many, and those who did not make a successful transition to work were obviously more at risk as a consequence. Young women who became pregnant in a study by Whitehead (2000) experienced much the same.

Other young people at the older end of the age range worried that they would not be able to make the appropriate transitions to adulthood, either because they were ill and much more dependent on family for support, or because they were carers of sick people themselves. One adolescent male carer in Earley *et al.*'s study (2007) reported that his caring responsibilities would get in the way of having a girlfriend and he was pessimistic about being able to accommodate caring responsibilities with his own transition to adulthood.

5.3 Having some control

Another cross cutting theme which runs across many accounts, but which comes through very starkly in work with troubled young people, is the need to exert some level of control over what is done to them and by whom. This was threaded through the accounts of normal school life – that children felt they did not have much say in what they did – but is very clear indeed where young people are in care or have acknowledged that there are concerns about their mental health and are trying to access treatment. Stanley (2007) found that looked after young people participating in focus groups emphasised a need to experience choice and control over help-seeking processes, especially in relation to issues of confidentiality and stigma. These young people had considerable experience of being at the receiving end of professional support and expressed clear opinions about the need for voluntary participation. For some, choosing whether or not to participate in therapy or counselling was important, as was choosing what information to divulge in counselling sessions. The participants also believed that care leavers themselves could provide a valuable service in supporting those in the looked after system since not only had they gone through it but they were 'positive models of survival'.

5.4 Coping strategies

How do young people cope with the stresses on them? Again the literature reveals quite a lot about the coping strategies used and, in turn, reveals what

young people value and interpret as important for mental health.

There was a consensus that good relationships with family, friends and supportive adults were key to improving mental health or recovering from mental health problems. Mothers in particular were described as a key source of support, in helping devise and persevere with coping strategies, talk through difficulties, act as a mediator with professionals and schools. Some young people (from ethnic minority groups in particular) reported that they were unlikely to seek support or advice from anyone outside the extended family. Children also reported fears of being a burden to mothers, or of contributing to parents' stress by over reliance on their support or of causing them to worry about children and young people's mental health problems.

Talking to someone about problems was viewed as both preventing escalation of problems and as a means of developing strategies for dealing with difficulties. However, the selection of a supportive adult beyond the family was widely reported as highly problematic. Taking problems to professionals such as teachers or counsellors was viewed as likely to lead to further stigma and to compromise individual anonymity and control. Few children and young people reported using the Internet or libraries for information on mental health. However, many pointed to television programmes as a source of information on mental health problems.

The importance of exerting control over a condition or experience was frequently referred to as forming a basis for tackling difficulties and helping make plans for the future. In Farmer's (2002) American study of depression, for instance, some understanding about the causes of depression helped young people to adopt a more positive approach even in situations where the underlying problems remained unresolved.

Children and young people identified mental health problems as 'serious' when their usual coping strategies no longer succeeded. For some young people, medication offered a means of dealing with difficulties, although some viewed it as exacerbating feelings of 'being different' and excluded.

5.5 Limitations of this review

We have noted already in the methods chapter the fact that the review is inevitably limited by the paucity of the literature that reports on children and young people's own views using methods that clearly allow them to have free voice (section 3.3). Many excluded studies examined young people from a professional point of view, asked them to respond to surveys clearly constructed by adults, or to respond to standardised inventories and so on. Even where the methods used had allowed young people to speak freely, the reporting of the results often merged young people's own conclusions with those inferred by the researchers, making them hard to disentangle. Researchers with a particular

disciplinary or methodological axe to grind frequently strayed beyond the reporting of what young people had said in ways which were not particularly useful for this project, albeit that they were perfectly appropriate within their own theory-building frameworks.

There remain many gaps in the literature that we were able to locate. Little that fell within our relevance and quality criteria, for instance, was helpful in examining the views of the youngest children. The views of minority ethnic communities are also largely unexplored in the literature reviewed here. Many samples included children of both genders and from a variety of social backgrounds, yet analysis was rarely performed at this level to examine differences (see also section 3.3.2).

The brief for this work notes that the material will feed into the development of indicators for the general population of children and young people and is not particularly designed to be relevant to specific (and problematic) sub-groups. However, it is an irony apparent in this review that some of the most insightful thinking about 'normal' states of mental health in young people comes from those who feel they have somehow been tipped beyond this by virtue of either having a diagnosed problem themselves (e.g. ADHD or depression) or those who sit outside the norm as the carer of a mentally ill parent, as a child with a chronic illness etc. This is perhaps not so surprising. Children and young people notoriously think little about their physical health either, and it is only the losing of it through physical injury, the onset of older age or illness which threatens it that they become aware of the fitness and good health that they are losing or missing.

5.6 Harden – ten years on?

What does this review tell us compared to the Harden *et al.* review (2001) which looked at literature up to 1999? It is important to note that the examination of children and young people's own accounts was only a small part of the study that Harden and his colleagues undertook. They were particularly interested in the divergence between professional views and young people's views and also in the shortfall between health promotion interventions and what young people said was useful or relevant.

In many ways the findings from this study reproduce and replicate the findings of that study. They show that young people's concerns continue to be within their immediate relationships and spheres of experience. The things that support good mental health (good family relationships, trusting friends, success at school, teachers who give individualised support when necessary) do not change. Nor do the obverse conditions seem to be any less detrimental to mental health. Chaotic, hostile family relationships, fickle friendships, bullying at school, failure to achieve remain as strong threats to young people. The data do not give us grounds to compare whether new pressures are emerging though some authors claim that issues around time pressures (pressure to fit it all in) are becoming

more evident for young people. The sorts of studies allowed through our relevance net would not allow these longitudinal analyses of change, as they would not have been experienced by individual children themselves and would only be evident in cohort studies using survey material.

5.7 Implications of the findings for the mental health indicators framework

The findings presented here are briefly reviewed in the following paragraphs against the draft framework for the children and young people's mental health indicators (Table 1).

An ideal *from the point of view of the commissioners* would have been to draw out the findings for mental health problems and mental wellbeing separately. It is clear from the literature that though we have tried to separate out those factors that either promote mental wellbeing or cause and exacerbate mental health problems, children and young people's own views do not easily lend themselves to this treatment. Thus, families are evidenced by young people as both a major source of strength, helping build mental wellbeing, and also the site or origin of the desperate feelings that can lead to mental health problems. Even for a single child, a family can be both of these things almost simultaneously. Strikingly, even children in the most dysfunctional households claim their family relationships as being very important to them. Similarly friendships can be the most important relationship for some young people at a certain point in their development, allowing sharing of troubles, rehearsal of solutions and so on. But friendship betrayed inevitably causes much anguish and distress.

It is no real surprise either that young people rarely attributed good or bad mental health to single factors. They were much more likely to visualise poor mental health as arising from an accumulation of troubles - the last straw breaking the camel's back. Thus, issues which would normally be handled well and would not cause too much distress could constitute a tipping point if a child was already under a great deal of stress from other quarters. The identification of single factors within the model does not do this understanding justice.

On the whole the findings presented here map reasonably well into the framework shown in Table 1. At the level of the self or individual there is endorsement for the categories of healthy living (specifically physical activity/sport) and general health as being critical to mental wellbeing. We did not find evidence in young people's own accounts about spirituality. The categories of 'learning and development' and 'emotional intelligence' are clearly adult named and derived from adult frameworks. In relation to the latter, children and young people talked about having energy and being able to engage and about being in control of their emotion and feelings, some of which may equate to emotional intelligence. Their understanding that mental wellbeing is fluid and contingent on a range of factors may also equate well to the latter – they

understand the importance of being self-aware and of needing to be self-monitoring.

Perhaps on the individual level the framework captures least well young people's own critical sense of needing to be 'normal'. This need defines appearance and conduct at many points in children's lives and makes it doubly difficult to bear the cross of any 'difference' or stigma.

At the family level of the framework the concentration in children and young people's accounts is on relationships rather than structure. What matters is the quality of interaction with parents and siblings and the support they provide, not how many parents a child has. This was almost never mentioned as critical. Parental mental health would seem to be an issue for young people. Young people with a mentally ill parent were critically aware of their own role as a carer for their parent and of having to live a life adapted to the parent's condition.

The school level of the framework emphasises school environment, peer relationships and engagement. In children and young people's accounts environment was mentioned relatively rarely, but relationships with teachers were seen as critical. 'Engagement' is, again, not a term that would be used by children and young people. Success at school was critical to young people, especially if teachers and parents acknowledged it. Children and young people agree on the importance of peer relationships at school, but most would make a distinction between the peer cohort or year group at school and their circle of friendships. This is currently not reflected properly in the draft framework. The peer group is important in marking what is normal and helping negotiate identity. The friendship group is critical in a different way for sharing stories and troubles, for working through problems and sharing both fun and bad things. This should perhaps be better reflected in the framework. The school level of the framework does not currently reflect the stress that young people feel in relation to testing and achievement and the management of all school related activities within a timeframe.

Young people identified another layer of adults who impact on their mental health. In some case these other adults were teachers, another reason why relationships with teachers (rather than just school environment) should be noted in the framework, but it also included other adults who were usually encountered in service contexts e.g. school nurses, counsellors, therapists. Their relations with young people could be critical, especially where young people had diagnosed or incipient mental health problems. We cannot see a location for these within the framework.

At the community level of the framework young people were more likely to stress the provision of facilities and activities and to equate the lack of these to boredom and poor mental health. Issues about safety were mentioned in some studies, particularly in relation to violence and levels of drug taking.

Only a small number of studies encouraged children and young people to explore the structural factors that lay behind their more immediate personal concerns. Poverty and its manifestation through homelessness the inadequacy and stress of life on benefits and so on were seen as lying behind the poor mental health of their parents in some cases, and homelessness was directly related to mental health problems amongst young self-harmers.

In the table that follows (Table 2) we attempt to summarise in very simplified form the issues which young people have identified as having an impact for good or ill on their mental health.

Table 2: Factors which children and young people view as having an Influence on their mental health

Self			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Keeping fit and healthy	Bourke and Geldens (2007) Girlguiding UK (2007) Johansson *et al.* (2007) White (2003)	Poor physical health and illness	Lynch & Spencer (2007) McCaffrey (2006) Woodgate (2006)
		Feeling abnormal (e.g. as a consequence of illness, or caring status, or being in care)	Earley *et al.* (2007) McCaffrey (2006) Stanley (2007)
Positive body image and appearance	Bourke and Geldens (2007) Girlguiding UK (2007) Johannson *et al.*, (2007) White (2003)	Poor body image and dissatisfaction with appearance	Girlguiding UK (2008)
Achievement and success	Armstrong *et al.* (2000) Bourke and Geldens (2007) Ellis (1999) Girlguiding UK (2007) Johannson *et al.*, (2007) White (2003)	Growing up too soon	Girlguiding UK (2008)
		Restrictive gender roles	van Daalen-Smith (2008)
Control over own choices	Farmer (2002) Stanley (2007)	Stigma of being diagnosed or identified as having mental health problem	Gallichan and Curle (2008) Kendall *et al.* (2003)

			Shelton (2004) Wisdom and Green (2004) Woodgate (2006)
Family			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Strong relationships, i.e. loving atmosphere, open communication with parents Close family involvement External relations (life outside family)	Armstrong *et al.* (2000) Barnardo's (2008) Bourke and Geldens (2007) Johansson *et al.* (2007) Joronen and Astedt-Kurki (2005) Shelton (2004) Sixsmith *et al.* (2007) White (2003)	Poor relationships, involving chaotic family lives, hostility between family members, divorce and family break up	Clark *et al.* (2007) Farmer (2002) Haydock (2001) Joronen and Astedt-Kurki (2005) Murray *et al.* (2005) Ryan-Wenger *et al.* (2005)
Support of parents in sharing problems, reaching decisions and helping through transitions	Armstrong *et al.* (2000) Bourke and Geldens (2007) Lee and Breen (2007) Stanley (2007)	Parental stress	Brobeck *et al.* (2007) Johansson *et al.* (2007)
		Parental mental health problems	Riebschleger (2004)
Unconditional support and safekeeping when troubled or in difficulty	Kendall *et al.* (2003) Lynch and Spence (2007) Woodgate (2006)	Over dependence on parents	Joronen and Astedt-Kurki (2005)

Family pets	Sixsmith *et al.* (2007)	Bereavement/loss of a family member	Barnardo's (2008) Haydock (2001) Joronen and Astedt-Kurki (2005) White (2003)
		Worry about a family member	Ryan-Wenger *et al.* (2005)
		Caring responsibilities, leading to feeling of difference, isolation, worries about future etc	Earley *et al.* (2007)
		Abuse (emotional, physical)	Farmer (2002)
School and Peer Relationships			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Well maintained school environments with facilities for children to meet and talk	Johansson *et al.* (2007)	Poor school environments perceived by pupils as resembling prisons or cages	Lee and Breen (2007)
		Pressures caused by need to achieve	Bourke and Geldens (2007) Brobeck *et al.* (2007) Girlguiding UK (2008)
Friendships and interaction with peers	Johansson *et al.* (2007) Lee and Breen (2007)	Pressures caused by shortage of time, too much homework	Bourke and Geldens (2007) Brobeck *et al.* (2007) Girlguiding UK (2008) Ryan-Wenger *et al.* (2005)
Good relationships with teachers,	Gallichan and Curle	Bullying by/unkindness from peers	Clark *et al.* (2007)

e.g. kind, respectful	(2008) Johansson *et al.* (2007)		Haydock (2001) Johansson *et al.* (2007) Lee and Breen (2007) McCaffrey (2006)
Development by schools of individualised support from teachers when facing difficulties	Gallichan and Curle (2008)	Poor relationships with teachers, e.g. being treated disrespectfully	Gallichan and Curle (2008) Lee and Breen (2007)
		Lack of support/understanding where special needs exist	Lynch and Spence (2007) McCaffrey 2006)
Friends			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Development of trusting friendships builds self-esteem	Ellis (1999) Girlguiding UK (2007) Girlguiding UK (2008) Johansson *et al.* (2007) Sixsmith *et al.* (2007)	Withdrawal of friendship through arguments and 'fall outs' causes trauma	Ellis (1999) Farmer (2002) Girlguiding UK (2007)
Friends used to work through problems	Armstrong *et al.* (2000)	Friendship lost by children and people falling outside norm, leaving them feeling isolated and stigmatised	Earley *et al.* (2007) Gallichan and Curle (2008) Hetherington and Stoppard (2002) Kendall *et al.* (2003) McCaffrey (2006) Riebschleger (2004) Stanley (2007) Whitehead (2000)

Friends support during particularly difficult times	Farmer (2002) Haydock (2001) Hetherington and Stoppard (2002) Lynch and Spence (2007) Woodgate (2006)	Friendships disrupted at transition points, causing isolation and distress	Lee and Breen (2007) Stanley (2007) Whitehead (2004)
Friends are fun	Sixsmith *et al.* (2007)	Death of a friend	Wisdom and Green (2004)
Adults outside the family			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Access to another adult outside family seen as supportive	Armstrong *et al.* (2000) Secker *et al.* (1999)	Need to access another adult or seek services seen as stigmatising	Shelton (2004)
		Knowledge of services and means of access poor among children and young people. Referral often only when problems very acute	White (2003)
Respectful attitudes towards children and young people – treating as 'whole individuals'	Woodgate (2006)	Poor professional attitudes towards children and young people's problems, e.g. dismissive, blaming, over-keen to medicate	Haydock (2001) Woodgate (2006)
Some control over choice of confidante and process	Stanley (2007)	Passing on of confidences from children and young people seen as undermining	Armstrong *et al.* (200)
Authentic experience of mentoring adults seen as helpful	Stanley (2007)	Lack of continuity of care for those receiving treatment or help	Stanley (2007)

Neighbourhood and community			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Provision of activities to prevent boredom and stop people getting 'into trouble'	Armstrong *et al.* (2000) Barnardo's (2008) Girlguiding UK (2007) Secker *et al.* (1999) White (2003)	Lack of activities to prevent boredom and stop people getting 'into trouble'	Armstrong *et al.* (2000) Girlguiding UK (2007) Secker *et al.* (1999) White (2003)
Sporting opportunities	Barnardo's (2008) Girlguiding UK (2007) White (2003)	Easy availability of drugs	Haydock (2001) White (2003)
Opportunities for helping other people	Girlguiding UK (2007)		
Unpressured spaces for young people to meet and interact (may need single sex spaces)	Girlguiding UK (2007)	Violence in the neighbourhood	Ryan-Wenger *et al.* (2005)
Structural			
Positive factors having impact on children and young people's mental health		**Negative factors having impact on children and young people's mental health**	
Appropriate support from agencies in terms of housing, employment etc	Bourke and Geldens (2007)	Poverty – including stigma it brings Money problems	Haydock (2001) Johansson *et al.* (2007) Riebschleger (2004) White (2003)
		Homelessness Instability of housing	Haydock (2001) Riebschleger (2004)

			White (2003)
		Unemployment	Johansson *et al.* (2007)
		Race/ethnicity	Kendall *et al.* (2003)
		Gender	Girlguiding UK (2008) van Daalen-Smith (2008)

6 References

Adi, Y., Killoran, A., Janmohammed, K., and Stewart-Brown, S. 2007, *Systematic review of the effectiveness of interventions to promote mental wellbeing in children in primary education: Report 1: Universal approaches*, National Institute for Health and Clinical Excellence, London.

Armstrong, C., Hill, M., and Secker, J. 2000, Young people's perceptions of mental health, *Children and Society*, vol. 14, no. 1, pp. 60-74.

Barnardo's 2008, *Welcome to the 'dead right now' world cafe: The roadshow of life, death and hope!* Barnardo's, Edinburgh.

Bayer, J. K., and Sanson, A. V. 2003, Preventing the development of emotional mental health problems from early childhood: recent advances in the field, *International Journal of Mental Health Promotion*, vol. 5, no. 3, pp. 4-16.

Bourke, L., and Geldens, P. M. 2007, Subjective wellbeing and its meaning for young people in a rural Australian center, *Social Indicators Research*, vol. 82, no. 1, pp. 165-187.

Brobeck, E., Marklund, B., Haraldsson, K., and Berntsson, L. 2007, Stress in children: How fifth-year pupils experience stress in everyday life, *Scandinavian Journal of Caring Sciences*, vol. 21, pp. 3-9.

Clark, E. E., Carlisle, S. S., Giard, A., and Turner, W. M. 2007, Speaking your mind: measuring the subjective quality of life of children with mental illnesses, *Issues in Mental Health Nursing*, vol. 28, no. 12, pp. 1277-1291.

Collinshaw, S., Maughan, B., Goodman, R., and Pickles, A. 2004, Time trends in adolescent mental health, *Journal of Child Psychology and Psychiatry*, vol. 45, no. 8, pp. 1350-1362.

Earley, L., Crushway, D., and Cassidy, T. 2007, Children's perceptions and experiences of care giving: A focus group study, *Counselling Psychology Quarterly*, vol. 20, no. 1, pp. 69-80.

Ellis, J. S. 1999, Adolescents' perceptions of self-esteem: A New Zealand Study, *International Journal of Adolescence and Youth*, vol. 7, pp. 349-358.

EPPI-Centre. 2007, *EPPI-Centre methods for conducting systematic reviews*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Farmer, T. J. 2002, The experience of major depression: adolescents' perspectives, *Issues in Mental Health Nursing*, vol. 23, no. 6, pp. 567-585.

Fox, C., Buchanan-Barrow, E., and Barrett, M. 2007, Children's understanding of mental illness: an exploratory study, *Child: Care, Health and Development*, vol. 34, no. 1, pp. 10-18.

Gallichan, D. J., and Curle, C. 2008, Fitting square pegs into round holes: the challenge of coping with attention-deficit hyperactivity disorder, *Clinical Child Psychology and Psychiatry*, vol. 13, no. 3, pp. 343-363.

Girlguiding UK. 2007, *Girls shout out! A UK-wide research report*, Girlguiding UK, London.

Girlguiding UK. 2008, *Teenage mental health: Girls shout out!*, Girlguiding UK, London.

Green, H., McGinnity, A., Meltzer, H., Ford, T., and Goodman, R. 2005, *Mental health of children and young people in Great Britain, 2004* Palgrave McMillan, Basingstoke.

Harden, A., Rees, R., Shepherd, J., Brunton, G., Oliver, S., and Oakley, A. 2001, *Young people and mental health: A systematic review of barriers and facilitators*, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London, London.

Haydock, E.-M. 2001, *No harm in listening*, Penumbra, Edinburgh.

Hetherington, A. J., and Stoppard, M. J. 2002, The theme of disconnection in adolescent girls' understanding of depression, *Journal of Adolescence*, vol. 25, pp. 619-629.

James, A., and Prout, A. 1997, *Constructing and reconstructing childhood,* Falmer Press, London.

Johansson, A., Brunnberg, E., and Eriksson, C. 2007, Adolescent girls' and boys' perceptions of mental health, *Journal of Youth Studies*, vol. 10, no. 2, pp. 183-202.

Joronen, K., and Astedt-Kurki, P. 2005, Familial contribution to adolescent subjective well-being, *International Journal of Nursing Practice*, vol. 11, pp. 125-133.

Kendall, J., Hatton, D., Beckett, A., and Leo, M. 2003, Children's accounts of attention-deficit/hyperactivity disorder, *Advances in Nursing Science*, vol. 26, no. 2, pp. 114-130.

Krackow, E., and Rudolph, K. D. 2008, Life stress and the accuracy of cognitive appraisals in depressed youth, *Journal of Clinical Child and Adolescent Psychology: The Official Journal For The Society of Clinical Child and Adolescent*

Psychology, American Psychological Association, Division 53, vol. 37, no. 2, pp. 376-385.

Lee, T., and Breen, L. 2007, Young people's perceptions and experiences of leaving high school early: an exploration, *Journal of Community and Applied Social Psychology*, vol. 17, no. 5, pp. 329-346.

Lynch, T., and Spence, D. 2007, A qualitative study of youth living with Crohn's disease, *Gastroenterology Nursing: The Official Journal Of The Society of Gastroenterology Nurses and Associates*, vol. 31, no. 3, p. 224.

McCaffrey, C. N., 2006, Major stressors and their effects on the well-being of children with cancer, *Journal of Pediatric Nursing*, vol. 21, no. 1, pp. 59-66.

Mental Health Foundation 1999, *Bright Futures. Promoting children and young people's mental health*, Mental Health Foundation, London.

Murray, C. D., Warm, A., and Fox, J. 2005, An Internet survey of adolescent self-injurers, *AeJAMH (Australian e-Journal for the Advancement of Mental Health)*, vol. 4, no. 1, pp. 1-9.

National Institute for Health and Clinical Excellence 2006, *Methods for development of NICE public health guidelines,* National Institute for Health and Clinical Excellence, London.

Parkinson, J. 2007, *Establishing a core set of national, sustainable mental health indicators for adults in Scotland: Final report*, NHS Health Scotland, Glasgow.

Parkinson, J. 2008, *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland: Report of the launch event of 21st April 2008*, NHS Health Scotland, Glasgow.

Public Health Institute for Scotland. 2003, *Needs assessment report on child and adolescent mental health: Final report*, Public Health Institute for Scotland, Glasgow.

Riebschleger, J. 2004, Good days and bad days: the experiences of children of a parent with a psychiatric disability, *Psychiatric Rehabilitation Journal*, vol. 28, no. 1, pp. 25-31.

Roose, G. A., and John, A. M. 2003, A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group, *Child: Care, Health and Development*, vol. 29, no. 6, pp. 545-550.

Rowling, L. 2002, School mental health promotion: Perspectives, problems and possibilities, *International Journal of Mental Health Promotion*, vol. 4, no. 4, pp. 8-13.

Ryan-Wenger, N. A., Sharrer, V. W., and Campbell, K. K. 2005, Changes in children's stressors over the past 30 years, *Pediatric Nursing*, vol. 31, no. 4, p. 282.

Scottish Executive 2004a, *A curriculum for excellence: The curriculum review group*, Scottish Executive, Edinburgh.

Scottish Executive 2004b, *Getting it Right for Every Child*, Scottish Executive, Edinburgh.

Scottish Executive 2005, *Health for all Children*, Scottish Executive, Edinburgh.

Scottish Executive 2006, *More Choices, More Chances: A Strategy to Reduce the Proportion of Young People not in Education, Employment or Training in Scotland*, Scottish Executive, Edinburgh.

Scottish Government 2007a, *Better health, better care: Action plan*, Scottish Government, Edinburgh.

Scottish Government 2007b, *The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 (Scotland)*, Scottish Government, Edinburgh.

Scottish Government 2008, *Early Years Framework*, Scottish Government, Edinburgh.

Scottish Government 2009, *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011,*Scottish Government, Edinburgh.

Secker, J., Armstrong, C., and Hill, M. 1999, Young people's understanding of mental illness, *Health Education Research*, vol. 14, no. 6, pp. 729-739.

Shelton, D. 2004, Experiences of detained young offenders in need of mental health care, *Journal of Nursing Scholarship*, vol. 36, no. 2, pp. 129-133.

Shucksmith, J., Summerbell, C., Jones, S., and Whittaker, V. 2007, *Mental wellbeing of children in primary education (targeted/indicated activities)*, National Institute for Health and Clinical Excellence, London.

Sin, J., Moone, N., and Harris, P. 2008, Siblings of individuals with first-episode psychosis: understanding their experiences and needs, *Journal of Psychosocial Nursing and Mental Health Services*, vol. 46, no. 6, pp. 33-40.

Sixsmith, J., Gabhainn, N. S., Fleming, C., and O'Higgins, S. 2007, Children's, parents' and teachers' perceptions of child wellbeing, *Health Education*, vol. 107, no. 6, pp. 511-523.

Stanley, N. 2007, Young people's and carers' perspectives on the mental health needs of looked-after adolescents, *Child and Family Social Work*, vol. 12, no. 3, pp. 258-267.

Taulbut, M., Parkinson, J., Catto, S., and Gordon, D. 2009, *Scotland's mental health and its context: Adults 2009,* NHS Health Scotland, Glasgow.

Tudor, K. 1996, *Mental health promotion: Paradigms and practice,* Routledge, London.

UNICEF 2007, *Child poverty in perspective: an overview of child well-being in rich countries*, UNICEF Innocenti Research Centre, Florence, Innocenti Report Card 7.

United Nations 1989, *Convention on the rights of the child*, United Nations, Geneva.

Vallotton, C. D. 2008, Signs of emotion: what can pre-verbal children "say" about internal states?, *Infant Mental Health*, vol. 29, no. 3, pp. 234-258.

van Daalen-Smith, C. 2008, Living as a chameleon: girls, anger, and mental health, *The Journal Of School Nursing: The Official Publication of The National Association of School Nurses*, vol. 24, no. 3, pp. 116-123.

Weare, K. 2004, *Developing the emotionally literate school,* Sage, London.

West, P., and Sweeting, H. 2003, Fifteen, female and stressed: changing patterns of psychological distress over time, *Journal of Child Psychology and Psychiatry*, vol. 44, no. 3, pp. 399-411.

White, J. 2003, *Scottish needs assessment programme report on child and adolescent mental health*, Scottish Development Centre, Edinburgh.

Whitehead, E. 2000, 'We should have known better:' exploring the impact of pregnancy on the mental health of teenage women, *Mental Health and Learning Disabilities Care*, vol. 4, no. 1, pp. 22-25.

Wisdom, P. J., and Green, A. C. 2004, "Being in a funk": Teens' efforts to understand their depressive experiences, *Qualitative Health Research*, vol. 14, no. 9, pp. 1227-1238.

Woodgate, R. L. 2005, A different way of being: adolescents' experiences with cancer, *Cancer Nursing*, vol. 28, no. 1, pp. 8-15.

Woodgate, R. L. 2006, Living in the shadow of fear: adolescents' lived experience of depression, *Journal of Advanced Nursing*, vol. 56, no. 3, pp. 261-269.

World Health Organization 2004, *Preconference on mental health of children and adolescents*, World Health Organization, Luxembourg.

World Health Organization 2005, *The health of children and adolescents in Europe. Fact sheet Euro/06/05*, World Health Organization, Copenhagen.

Appendices

Appendix 1: Search strategies

Applied Social Sciences Index and Abstracts (ASSIA)

AB = Abstract (key word search)
DE = Descriptors (subject heading search)

Terms for children and young people:

The following were combined with the Boolean Operator ‘OR’

DE Adolescence, DE Adolescent Boys, DE Adolescents, DE Adolescent Girls, DE Children, DE Young People

Terms for mental health:

The following were combined with the Boolean Operator ‘OR’

DE Emotion (exploded to include all ‘affective experiences’ and ‘feelings’), DE Mental Health, DE Mental Illness, DE Psychological Distress, DE Psychological Wellbeing, DE Wellbeing, AB Well-being, DE Coping, DE Emotional Coping, DE Life Satisfaction, DE Stress (exploded to: ‘life stress’, ‘school stress’, ‘social stress’), DE Resilience, DE Confidence.

In ASSIA well-being is also used for well being.

Terms for views and opinions:

The following were combined with the Boolean Operator ‘OR’

DE Attitudes, DE Beliefs, DE Opinions, DE perceptions, DE Perspectives, DE Understanding.

Once all of the terms for each section had been combined with ‘OR’ the results were then combined with ‘AND’ to give the final results.

Limiters

Date 1999-2009, Journal articles only, English only.

Cumulative Index to Nursing and Allied Health Literature (CINAHL)

AB = Abstract (key word search)
MH = Exact Subject Heading (subject heading search)

Terms for children and young people:

The following were combined with the Boolean Operator 'OR'

MH Child, MH Child: Preschool, MH Adolescent, AB Young People.

Terms for mental health:

The following were combined with the Boolean Operator 'OR'

MH Mental Health, MH Psychological Well-Being, MH Attitude to Mental Illness, MH Mental Disorders, AB Wellbeing, AB Well being, MH Emotions (exploded to include all emotions), AB Distress, AB Life Satisfaction, AB Self Esteem, MH Confidence, MH Stress.

In CINAHL the terms well being and well-being returned the same results therefore only one of these terms were used in the search.

Terms for views and opinions:

The following were combined with the Boolean Operator 'OR'

MH Attitude, MH Attitude to Health, MH Perception, AB Opinion, AB Perspective, AB Understand, AB Belief, MH Health Beliefs, MH Attitude to Illness

Once all of the terms for each section had been combined with 'OR' the results were then combined with 'AND' to give the final results.

Limiters

Published from 01 1999- 01 2009, Exclude pre- CINAHL, exclude MEDLINE records, Language: English Age groups: Infant 1-23 months, Preschool 2-5 years, Child 6-12 years, Adolescence 3-18 years.

International Bibliography of the Social Sciences (IBSS)

AB = Abstract (key word search)
DE = Subjects (subject heading search)

Terms for children and young people:

The following were combined with the Boolean Operator 'OR'

DE Children, DE Pupils, DE Adolescents, DE Adolescence, DE Youth, DE Rural Youth, DE Urban Youth

Terms for mental health:

The following were combined with the Boolean Operator 'OR'

DE Mental Health, DE Mental Illness, DE Mental Stress, DE Well-being, DE Emotions (exploded to include all emotions), DE Depression, DE Self-Concept, DE Self Esteem, AB Mental 'N1' Well*, AB Wellbeing, DE Feelings, AB Coping.

Terms for views and opinions:

The following were combined with the Boolean Operator 'OR'

DE Attitudes, DE Opinion, DE Perception, DE Self Perception, DE Social Perception, DE Beliefs, AB Understand, AB Perspective.

Once all of the terms for each section had been combined with 'OR' the results were then combined with 'AND' to give the final results.

Limiters

Date published: 01 1999- 01 2009, English only, Journals only

MEDLINE

AB = Abstract (key word search)
MH = Exact Subject Heading (subject heading search)

Terms for children and young people:

The following were combined with the Boolean Operator 'OR'

MH Adolescent, MH Child, MH Child: Preschool.

Terms for mental health:

The following were combined with the Boolean Operator 'OR'

MH Mental Health, MH Mental Disorders, MH Depression, MH Emotions (exploded to include all emotions), MH Self Concept, MH Life Satisfaction, MH Personal Satisfaction, MH Stress, AB Wellbeing, AB Well-being, AB Resillien*, AB Confiden*.

Terms for views and opinions:

The following were combined with the Boolean Operator 'OR'

MH Attitude, MH Attitude to Health, AB Perspectiv*, AB Opinion, AB Belief, AB Perception, AB Understand.

Once all of the terms for each section had been combined with 'OR' the results were then combined with 'AND' to give the final results.

Limiters

Date of publication from 01 1999 – 01 2009, English language, Human, age related: Child, Preschool: 2-5 years, Child 6-12 years, Adolescent: 13-18 years, Publication type: Journal article

psycINFO

AB = Abstract (key word search)
DE = Subjects [exact] (subject heading search)

psycINFO was unique in that it organised papers under the terms: adolescent attitudes and child attitudes, this included opinions and understandings under one heading. Therefore, it was only necessary to search for these terms and terms about mental health and mental wellbeing as follows.

Terms for children and young people, and views and opinions:

The following were combined with the Boolean Operator 'OR'

DE Adolescent Attitudes, DE Child Attitudes

Terms for mental health:

The following were combined with the Boolean Operator 'OR'

DE Mental Health, DE Wellbeing, DE Life Changes, DE Life Satisfaction, DE Distress, DE Stress, DE Mental Disorders, DE Chronic Mental Illness, DE Self Esteem, DE Self Confidence, DE Self Perception, DE Emotional States, DE Emotions (exploded to include all emotions), DE Depression, DE Coping.

Once all of the terms for each section had been combined with 'OR' the results were then combined with 'AND' to give the final results.

Limiters

Publication year from: 1999- 2009, Peer-reviewed, English language, Human, Document type: journal.

Social Sciences Citation Index (SSCI)

TS = Topic (subject heading search)

Terms for children and young people:

The following were combined with the Boolean Operator ‘OR’

TS Adolescent, TS Teen, TS Child, TS Young People, TS Young Person, TS Young Adult.

Terms for mental health:

The following were combined with the Boolean Operator ‘OR’

TS Mental Health, TS Mental Well$being, TS Depression, TS Life Satisfaction, TS Mental Disorder, TS Mental Illness, TS Emotion, TS Mental Distress, TS Self Esteem, TS Coping, TS Feelings, TS Anxiety, TS Sad, TS Stress, TS Confidence.

Terms for views and opinions:

The following were combined with the Boolean Operator ‘OR’

TS Attitude, TS Belief, TS Perception, TS Understanding, TS Perspective, TS Opinion, TS View.

Once all of the terms for each section had been combined with ‘OR’ the results were then combined with ‘AND’ to give the final results.

Limiters

Timespan 1999-2008

Appendix 2: Inclusion/exclusion criteria tool

(1)	Reports children and young people's **own** understanding of mental illness/ wellbeing Or Reports children and young people's **own** understanding of factors that contribute to or are detrimental to their mental wellbeing	Yes	Progress with other inclusion/exclusion criteria
		No	Reject
(2)	Written in English	Yes	Progress with other inclusion/exclusion criteria
		No	Reject
(3)	Peer-reviewed	Yes	Progress with other inclusion/exclusion criteria
		No	Reject/ Retain as 'grey' literature
(4)	Primary research	Yes	Progress with other inclusion/exclusion criteria
		No	Reject/If a review, retain for possible background literature
(5)	Focuses on correct age group (0-18yr olds)	Yes	Progress with other inclusion/exclusion criteria
		No	Reject, but NB: use discretion with top end of age group but no more than 24yrs - discuss with team
(6)	Undertaken in developed country (HDI>0.8)	Yes	Progress with other inclusion/exclusion criteria
		No	Reject. Group UK studies together then group rest of world. Preference must be given to UK examples
(7)	Study published between 1999 and present day	Yes	Accept into review
		No	Reject

- Once studies have been assessed for inclusion and grouped as stated above, those which have met all criteria to progress should be quality assessed then data extracted if applicable.

Appendix 3: Quality assessment tool

<table>
<tr><td colspan="2"></td><td>Passed?</td><td>Yes
No</td></tr>
<tr><td colspan="1">Reference Details:
• Author, Year of Publication, Title, Journal</td><td colspan="3"></td></tr>
<tr><td>Checklist completed by:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Aims</td></tr>
<tr><td>Are the aims and objectives clearly stated?
(Hypothesis clear/appropriate for quantitative studies)</td><td>Clearly described
Unclear
Not reported</td><td colspan="2" rowspan="2">Comments:</td></tr>
<tr><td>Is a qualitative (or quantitative) approach appropriate to answer the research question?</td><td>Appropriate
Unclear
Not appropriate</td></tr>
<tr><td colspan="4">Study design</td></tr>
<tr><td>Is the research question clearly defined and focused?</td><td>Clearly defined and focused
Unclear
Not defined
Not focused</td><td colspan="2" rowspan="2">Comments:</td></tr>
<tr><td>Are the methods appropriate to allow the level of analysis and inference required to answer the research question(s)?
(sample size, power, distribution for quantitative)</td><td>Appropriate
Unclear
Inappropriate</td></tr>
<tr><td colspan="4">Recruitment and data collection</td></tr>
<tr><td>Is there a clear description of the sample?</td><td>Clear
Unclear
Not reported</td><td colspan="2" rowspan="5">Comments:</td></tr>
<tr><td>Is this appropriate for the research question?</td><td>Appropriate
Unclear
Not appropriate</td></tr>
<tr><td>Is the recruitment or sampling strategy appropriate to the aims of the research?</td><td>Appropriate
Unclear
Not appropriate</td></tr>
<tr><td>Does the method of data collection yield the types of evidence that will answer the research question(s)?</td><td>Yes
No
Unsure</td></tr>
<tr><td>Are the roles of the researchers clearly described?</td><td>Clear
Unclear
Not reported</td></tr>
</table>

Have ethical issues been addressed adequately?	Adequate Unclear Not adequate	
Is the socio-economic/ cultural context in which the research was carried out adequately described?	Yes No Unsure	
Data analysis		
Is the method of data analysis described clearly?	Clear Unclear	Comments:
Is the method of data analysis sufficiently rigorous? (parametric assumptions, procedures to ensure reliability/validity for quantitative)	Rigorous Not rigorous	
Findings/ interpretation		
Are the findings properly evidenced by data?	Evidenced Not well evidenced	Comments:
Are the findings internally coherent/ credible (valid)?	Valid Unclear Potential bias	
Are the findings relevant?	Relevant Unclear Limited relevance	
Implications of research		
Are the implications of the study clearly reported?	Clearly reported Unclear	Comments:
Is there adequate discussion of the study limitations?	Adequate Inadequate Not reported	
Overall assessment of the study		
High Medium Reject	++ + -	Comments:

Appendix 4: Data extraction tool

Name of reviewer	
Date of data extraction	
Publication details:	
Author(s)	
Title	
Year of publication	
Journal	
Volume & issue	
Page number(s)	
Country (where conducted)	
Study type (Quant, qual, 'grey', consultation etc…)	
Study aims	
Definition/ understanding of mental health used in the study i.e. all mental health, mental health problems, coping etc…	
Participant/sample details:	
Age of participants	
Gender	Female only Male only Mixed Unclear
Ethnicity recorded?	Yes (give details) No Unclear
Social class recorded (please include details such as measures of socio-economic status, deprivation etc…)	Yes (give details) No Unclear
Specific special educational needs/ disability/ MH symptomology? (please include details such as particular vulnerabilities)	Yes (give details) No Unclear
Any other useful information recorded?	Yes (give details) No
Methodology & data analysis:	
Study design Give details	

Recruitment procedure: Give details (e.g. letters of invitation, telephone contact etc…)	
Sample size Give number Is there an indication of sample bias? Is sample size appropriate?	
Sample drop out Give details of numbers of drop outs/attrition from study and reasons	
Consent Informed; implied; other (give details)	
What methodology was used to collect data? Interview (face to face/ telephone); focus group; observation; diary entries; other? Give details	
What methodology was used to analyse data? Give details	
Did the authors give a rationale for their chosen data analysis tool?	Yes Give details No Unclear
Do the authors give details of how reliability of the analysis tools was assessed? Give details (e.g. inter-rater reliability, triangulation of methods, data, researchers etc…)	
Are views obtained those of the CHILDREN AND YOUNG PEOPLE not the researchers	
Results/study outcomes:	
What were the main findings of the study? Give details	
Do the authors discuss the reliability of their findings?	Yes (give details) No Unclear
Are there any obvious shortcomings in the methodology/ analysis?	Yes (give details) No Unclear
What do the authors conclude? Give details	

Do findings reflect the results?	Yes No (discuss)
Overall assessment:	
Any notable competing interests between funding body and investigation?	Yes (give details) No
Overall rating of quality of article? Refer to previous quality assessment sheet	High quality (++) Medium quality (+) Low quality (-)
Does article adds to knowledge base?	Yes (give details) No (give details)
Comments	

Appendix 5: List of sites searched for ‘grey’ literature

Organisations which were contacted for information and their WebPages searched for ‘grey’ literature.

1. 11 Million
2. Action for Children
3. Barnardo’s
4. Centre for Research on Families and Relationships
5. Family and Parenting Institute
6. Girlguiding UK
7. Joseph Rowntree Foundation
8. Mind
9. Penumbra
10. Pupil Inclusion Network Scotland
11. Scottish Development Centre for Mental Health
12. The Mental Health Foundation
13. The Prince’s Trust
14. Young Minds
15. Young Scotland in Mind
16. Youth Access

Appendix 6a: Evidence tables – peer-reviewed

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Armstrong C, Hill M, Secker J 2000 Young people's perceptions of mental health Children and Society 14, 60-72 Peer-reviewed journal article. Quality assessment ++	Qualitative(ethnographic approach). Data was collected using focus group discussions and individual interviews.	To explore the attitudes and perceptions of a broad range of young people aged 12-14 towards positive mental health and mental illness. Definition/understanding: Positive mental health and mental illness.	N = 145, UK (Scotland) School A, n=35 School B, n=35 School C, n=21 School D, n=29 Community agencies, n=25. Ages ranged from 12-14 years. Participants were young people from a variety of social backgrounds who attended mainstream schools in rural, suburban and inner city areas of Scotland. School A served an inner city area with a high rate of unemployment, schools B & C served largely suburban areas that are significantly more affluent and school D was situated in a rural area serving a large locality and a mixed socio-economic population. Gender was mixed and girls were almost twice as many as boys. Participants were from diverse minority ethnic backgrounds.	Young people from most deprived areas associated mental health with being disturbed, feeling confused, crying, lashing out and hitting people and getting upset. In contrast those from suburban areas associated it with either lack of mental illness or in terms of happiness and confidence. Young people identified four main factors as contributing to mental health: family and friends having people to talk to, personal achievements and feeling good about oneself. Young people identified the need for adults to make young people feel safe, both physically and emotionally. They described the common way of dealing with feelings of anger or frustration was to take it out on inanimate objects, on siblings or, less commonly, on other young people. The authors conclude that young people have some very definite views about the issues which affect their positive mental health and the support they require. Parents and professionals can help them by remembering they are people in their own right with strong views about what they want and need from those around them.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Bourke L and Geldens M P 2007 Subjective wellbeing and its meaning for young people in a rural Australian center Social Indicators Research 82, 165-187 Peer-reviewed journal article. Quality assessment ++	Mixed methods Quantitative data was collected using a short self-completion questionnaire with standard measures namely: the self-reported health status scale, a three point scale assessing happiness, a nine item measure of the Subjective Wellbeing (SWB), and a five item Satisfaction with Life (SWL) scale. It also asked about demographic data. Qualitative data was collected using semi-structured interviews.	To explore young people's meanings of wellbeing as well as their levels of wellbeing. Definition/understanding: Wellbeing	N=91, Australia Students, n=56 Other young people from services, n=35 The sample comprised of young people who were aboriginal, not at school, young mothers, young people from refugee families, unemployed young people and young people living independently. Participants' age ranged from 16-24 years old No discussion on gender, ethnicity and socio-economic status	Key components of wellbeing for young people were found to include relationships, psychological dimensions and personal issues while family and 'pressure' impacted wellbeing. For most young people, wellbeing was multidimensional, holistic and centred around their own lives. The authors conclude that health, sociology of youth and psychological approaches all contribute to young people's perspectives of wellbeing and need to be incorporated into a more holistic measure of SWB for young people.
Brobeck E, Marklund B, Haraldsson, Berntsson L 2007 Stress in children: how fifth-year pupils experience stress in everyday life Scandinavian Journal of Caring Sciences	Qualitative (Explorative and descriptive design) Data was collected by use of semi-structured tape recorded interviews.	To illuminate how fifth-year pupils experience stress in their everyday life. Definition/understanding: Psychological wellbeing	N=29, Sweden Children's age ranged from 11-12 years old (Fifth year pupils) Sample broken down by gender: n=18 females n=11 males All children had a Swedish cultural background	The five key constituents which emerged following a synthesis of the transformed units were: fear of being late, not having sufficient time, physical and mental consequences, both a positive and negative feeling and experiencing significant others' stress. The study demonstrated that stress is a part of children's everyday life. The

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
21, 3-9 Peer-reviewed journal article Quality assessment ++			Participants were selected from two schools one at the outskirts of town and the other in a rural community. They were estimated to be equivalent to the socio-economic conditions and situated in areas with apparently few social problems	children described stress that was often acute and linked to situations that occur in everyday life. The authors concluded that the results of the study can assist in identifying the factors behind the stress experienced by children which in turn will facilitate observation and intervention when a child exhibits stress symptoms.
Clark E E, Carlisle S S, Gaird A, Turner W M 2007 Speaking your mind: Measuring the subjective quality of life of children with mental illness Mental Health Nursing 28, 1277-1291 Peer-reviewed journal article. Quality assessment +	Mixed methods. Survey of children's quality of life using the PedsQL. Open ended questions to elicit children's own opinions on the effect of their mental illness on their quality of life	To evaluate the PedsQL scale for use in children with mental illness. To determine whether the PedsQL scale captures the most salient concerns of children and adolescents and their goals for quality of life Definition/understanding: Quality of life = individual's perception of his or her position in life in the context of the culture and value systems in which they live.	N=53, USA Children attending an outpatients department of a small private psychiatric hospital. All were diagnosed and being treated with medication for mental illness. Children's ages ranged from 5-18 years old broken down into age categories: n=6, 5-7 years old n=21, 8-12 years old n=26, 13-18 years old Sample broken down by gender: n=36 males n=17 females No discussion of ethnicity/ socio-economic status.	From the content analysis of qualitative data 6 themes were derived these were: -Chaotic family relationships -Desire for acceptance -The experience of stigma -The experience of being different -The experience of grief and loss -A desire for self-efficacy The authors conclude that whilst the PedsQL may be an effective tool to use in psychiatric assessment it could not give a complete representation of what a child's life quality is.
Earley L, Cushway D, Cassidy T 2007 Children's	Qualitative Data on children was collected using focus	The aim of the study was to explore young carer's appraisals of the impacts of care giving and the ways	N=17, Ireland Participants were children caring for someone with AIDS, mental health or	The main categories identified included: • Stressors (feeling different, identity, responsibility,

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
perceptions and experiences of care giving: A focus group study Counselling Psychology Quarterly 20 (1), 69-80 Peer-reviewed journal article. Quality assessment ++	group discussions and individual semi-structured interviews.	they cope with these demands Definition/understanding: Coping	drug and alcohol problems. Children's age ranged from 10-16 years old Mean age =13.11years (Focus group 1) Mean age =11.39years (Focus group 2) By gender: n=3 females n=14 males Four of the participants were Asian and the remainder were Caucasian. One group of participants was situated in an inner city and the other in a market town	relationships) • Coping strategies • Appraisal (threats to self, controllability, beliefs about responsibility) Findings suggest that societal responses compound the identity issues by excluding and isolating children, resulting in feelings of being different. Some children reported immersing themselves in their caring role as a way of coping, thus further isolating themselves and exacerbating the separation problems. The authors conclude that there is need to recognise the importance of caring to a young person's identity and self-esteem in spite of the pervasive stressful influence it may have upon their lives.
Ellis J S 1999 Adolescents' perceptions of self-esteem: A New Zealand study International Journal of Adolescence and Youth 7, 349-358 Peer-reviewed journal article	Qualitative Data was collected using semi-structured interviews	To explore the way(s) in which adolescents view self-esteem, and to assess the degree to which their views were concurrent with the conceptualisations of self-esteem suggested by existing psycho-logical theory and research. Definition/understanding: Emotional problems	N=24, New Zealand Participants were from 2 secondary schools in the Waikato district, New Zealand. 12 participants from each school. Participants ranged from 14years to 15 years 2 months. The mean age was 14 years 6 months. Sample broken down by gender: n=12 males	Results of the study showed that those interviewed predominantly viewed self-esteem as a function of external factors, as relatively transient, and as often affected by specific contexts or events. Most respondents suggested that how well an individual did at school was related to their self-esteem, and mere presence of others would enhance an individual's self-esteem. However, events such as death, the loss of a

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Quality assessment ++			n=12 females The sample comprised mostly adolescents of European descent (eight males and nine females), the remainder being of Maori descent (four males and three females). No discussion about social-economic status.	job or just things going wrong during the day could cause a sudden loss in self-esteem. The authors conclude that their findings appear disparate with the psychological literature, in that they provide limited support for the dominant conceptualisation of self-esteem as internal, stable and global.
Farmer J T 2002 The experience of major depression: Adolescents' perspectives Issues in Mental Health Nursing 23, 567-585 Peer-reviewed journal article. Quality assessment ++	Qualitative (Phenomenological approach) Data was collected using in-depths, audio taped interviews.	To explore the experience of major depression from the viewpoints of adolescents in an effort to provide a more comprehensive description of the disorder. Definition/understanding: Mental health problems (Depression)	N=5, USA Participants were adolescents from a south western outpatient mental health facility diagnosed as depressed by qualified therapists. Participants ranged from 13-17 years old Sample broken down by gender: n=2 males n=3 females Participants were Caucasian, Hispanic and African American. No discussion on social-economic status.	8 theme categories emerged from the analysis: dispirited weariness, emotional homelessness: sense of aloneness, emotional homelessness: no safety where expected, unrelenting anger, parental break-up: caught in the middles, spectrum of escape from pain, perspectives on friendship, gaining a sense of getting well. Adolescents focused on anger, fatigue, and interpersonal difficulties as characteristic of depression. The authors concluded that their results call for increased awareness of the unique aspects of adolescents, an examination of adolescent-accessible services and further clarification of the roles of friends and siblings in the disorder.
Fox C, Buchanan-Barrow E, Barrett M 2007 Children's	Mixed methods Data was collected using semi structured interview techniques	To investigate children's thinking about mental illness by employing a well-established framework of adult illness understanding.	N= 89, UK (England) Participants ranged from 5-11 years old. Age by categories:	Results indicated a developmental trend in the children's thinking about mental illness; there was an increase in the children's understanding of the causes, consequences, curability and

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
understanding of mental illness: an exploratory study. Child: Care, Health and Development 34 (1) 10-18 Peer-reviewed journal article. Quality assessment ++	and card selection tasks. Each child was read a story about some people with different sorts of illnesses, then they would be asked some questions about the people using cards, then they would be asked to chose whichever card they felt to be right	Definition/understanding: Mental health problems	'Young' group, n=29 (5-7 years, mean age=6.45 years, SD=0.56) 'Middle' group, n=30 (7-9 years, mean age=8.47 years, SD=0.57) 'Old' group, n=30 (10-11 years, mean age=10.50 years, SD=0.51). Sample broken down by gender: Young group (Males, n=14 and females, n=15) Middle group (Males, n=15 and females, n=15) Old group (Males, n=17 and females, n=13) No discussion of ethnicity/socio-economic status	timeline of mental illness with age. The older children demonstrated a more sophisticated and accurate thinking about mental illness compared with the younger children. The girls exhibited more compassion, showing greater social acceptance compared with the boys. The authors concluded that five component Leventhal model of adult illness understanding, provides a useful framework within which to investigate children's knowledge and understanding of mental illness.
Gallichan J G and Curle C 2008 Fitting square pegs into round holes: The challenge of coping with Attention-Deficit Hyperactivity Disorder Clinical Child Psychology and Psychiatry 13 (3) 343-363 Peer-reviewed journal article Quality assessment	Qualitative Audio taped semi structured interviews were used to collect data.	To extend the understanding of the meaning and experience of ADHD from young people's perspectives with particular reference to social context, coping with challenge and times when ADHD is not a challenge. Definition/understanding: Mental health problems	N=12, UK (England) Participants lived in either rural village locations or small towns or cities. Each participant had received a diagnosis of ADHD according to DSM-IV criteria from either a consultant psychiatrist or consultant paediatrician. Participants' age ranged from 10 years 11 months to 17 years 4 months. Sample broken down by gender: n=10 males n= 2 females All were of white British ethnicity	The findings suggested a reciprocal relationship between young people and their social context, with challenges of ADHD formulated as a mismatch between the two; young people were like square pegs trying to fit into rigid round holes. This 'vicious cycle' led young people to feel out of control and have low self-esteem. ADHD was experienced as less challenging when the environment was adaptable and flexible, and when young people experienced the support and acceptance of others. Such environments may motivate young people to make their own changes, and fostered a sense of agency and positive sense of self.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
++			No discussion about social class	The authors conclude that social contexts can have a profound impact on young people with a diagnosis of ADHD. Challenges are not created by these young people themselves but by the mismatch between their needs and the environmental set up.
Hetherington A J and Stoppard M J 2002 The theme of disconnection in adolescent girls' understanding of depression Journal of Adolescence 25, 619-629 Peer-reviewed Journal article Quality assessment ++	Qualitative Data was collected using audio-taped semi-structured interviews which took the form of a guided conversation.	To explore how adolescent girls understand depression and its meaning in their lives. Definition/understanding: Mental health problems (Depression)	N=14, Canada Thirteen participants were in grade 10 and one in grade 9 Participants aged ranged from 14-17 years old. Majority (n=11) were 15 at the time of the interview All participants were female. No discussion of socio-economic status.	The predominant theme emerging from the interviews was that of depression as ***disconnection from others***. Depression was described as a loss of social connection or social withdrawal Depression was also linked to socialisation, it was further identified that depression arises from troubles associated with relationships. Participants thought that talking openly with someone who will listen is the best option in coping with depression. Participants also thought that depressed people should not try to cope alone. The authors conclude that regardless of whether girl's desire or need for affiliation is inherent, learned, or both, it is useful and important for researchers and mental health professionals to know that connection with others is an important part of girls' understandings of depression.
Johansson A, Brunnberg E,	Qualitative (descriptive phenomenological	Research questions: What are the perceptions of	N=48, Sweden	The adolescents perceived mental health as an emotional experience,

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Eriksson C 2007 Adolescent girls' and boys' perceptions of mental health Journal of Youth Studies 10 (2), 183-202 Peer-reviewed journal article. Quality assessment ++	approach used) Data was collected using semi-structured individual and focus group interviews	'mental health' held by adolescent girls and boys? What are the perceived determinants of mental health? What are the gender-based expectations? Definition/understanding: Emotional experience	Participants were adolescents from two schools in two small towns in the middle of Sweden. Participants were 13 and 16 years old Girls aged 13years, n=12 Girls aged 16 years, n=18 Boys aged 13 years, n=6 Boys aged 16 years, n=12 Sample broken down by gender: n=18 males n=30 females Participants were from diverse cultural backgrounds No information is recorded about social class	which could be described as positive or negative. The emotions could be internal feelings or feelings towards other people Family is the most important determinant for young people's mental health, closely followed by friends. Neither girls nor boys believed that there were any large differences in mental health between girls and boys. Age differences seemed to be more important than gender in the perception of mental health by children. The authors concluded that more research on the perceptions and beliefs of young people and of differences between girls and boys is needed.
Joronen K and Astedt-Kurki P 2005 Familial contribution to adolescent subjective wellbeing International Journal of Nursing Practice 11, 125-133 Peer-reviewed journal article. Quality assessment	Qualitative Data was collected using semi structured interviews which concentrated on adolescents subjective experiences and perceptions of the familial factors related to their wellbeing	To understand better and in more detail the diversity of familial factors contributing to adolescent SWB from adolescents' point of view. Definition/understanding: Psychological distress and substance use (ill-being)	N=19, Finland Sample was from 9 different schools n=10, seventh graders n= 9, ninth graders Three participants reported to have a chronic illness (e.g. musculoskeletal disease). Participants age ranged from 12-16 years old Gender was mixed with 12 females and 7	Teenagers described familial contribution to their satisfaction in terms of experiences of a comfortable home, emotionally warm atmosphere, open communication, familial involvement, possibilities for external relations and a sense of personal significance in the family. Three themes related to ill-being emerged: familial hostility, ill-being or death of a family member, as well as excessive dependency. The authors conclude that their

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
++			males. No discussion of ethnicity. The self-reported socio-economic status of the parents were as follows: five of the mothers and six of the fathers were senior white collar workers, five of the mothers and four of the fathers were junior white collar workers, and six of the mothers and fathers were manual workers. Three participants did not report the occupation of parents. Nine adolescents lived in an intact family, seven in a single-parent family and three in a step-family. Nine participants had one sibling, five had two or more and five participants had no siblings living at home.	findings expand the understanding of the diversity of familial contribution to adolescent life and subjective wellbeing. They challenge nurses to focus on the adolescent's self-perception of familial effects on wellbeing and on promotion of familial factors in adolescent health issues.
Kendall J, Hatton D, Beckett A, Leo M 2003 Children's accounts of Attention-Deficit/Hyperactivity Disorder Advances in Nursing Science 26 (2), 114-130 Peer-reviewed journal article. Quality assessment	Qualitative Data was collected using in-depth semi structured qualitative interviews. Observations during family contacts were written as field notes in a series of brief narratives, or as family portraits.	To seek further documentation of the problems associated with ADHD To seek further clarification of what it is like to live with ADHD, from the perspective of the children themselves Definition/understanding: Mental health problems	N=39, USA All participants had been diagnosed with ADHD by their health care providers Children's age ranged from 6-17 years old Mean age was 11.2 years old. Sample broken down by gender: n=26 male n=13 female Fifteen participants self-identified as African American (11 boys and 4 girls), 13 as Hispanic of mostly	Six categories emerged from the data: • Problems (learning/thinking, behaving, feeling) • Meaning and identity(hyper, bad/trouble/weird, illness/normal) • Pills (positives, negative) • Mom • Causes • Ethnicity/race/racism Participants in this study knew they had problems; they saw themselves as different from their peers and knew life would be easier for them and their families if they did not have ADHD.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
++			Mexican descent (11 boys and 2 girls), 9 as Caucasian (4boys and 5 girls), and 2 as biracial (Hawaiian/Caucasian girl and Samoan/Hispanic boy) Twelve families had an annual income below $10000, 6 families from $10000 to $29000, 16 families from $30000 to $75000 and 4 families over $75000 Seventeen families were single parent (16 single mothers and 1 single father) and 21 were 2-parent families.	Some of the children thought of themselves as abnormal, using words such as “retarded,” “bad,” “weird,” or “whacko.” The authors conclude that helping families who have children with ADHD helps to replace blame and criticism which would help to decrease symptoms of the disorder.
Krackow E & Rudolph K D 2008 Life stress and the accuracy of cognitive appraisals in depressed youth Journal of Clinical Child & Adolescent Psychology 37 (2) 376-385 Peer-reviewed journal article. Quality assessment + +	Mixed Methods Separate face to face structured and semi structured interviews with young people & caregivers Questionnaires	To examine the experience of depressed youths of stressful life events and their subjective appraisals of these events. Definition/understanding: Mental illness	A sub-group of 89 youths were included for this study, chosen from a larger study of 167 youths, USA. Young people who were assessed through the use of the Children’s Depression Inventory as showing depressive symptoms and met the DSM IV criteria for a diagnosis of depression (but did not display symptoms of any axis I psychiatric disorder) were included in this study. Age ranged from 9.6-14.8 years old. Mean age was 12.44 SD= 1.21 Sample broken down by gender: n=45 males n=44 females	Those young people with sub-syndromal depression experienced more dependent non-intrapersonal stress and overestimated the stressfulness of it than the non-symptomatic and clinically depressed groups The authors highlight that practitioners must use integrative theories of depression and consider actual environmental experiences and stressors alongside young people’s interpretation of them

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
			This sub-sample of depressed youths was taken from a larger sample of young people. The larger sample was deemed as ethnically diverse: Caucasian (77.8%), African American (12.6%), Native American (1.8%), Latino (0.6%) and Other (0.6%) Diverse economic backgrounds measured by household income. Also mix of young people from small urban and rural towns in the USA	
Lee T and Breen L 2007 Young people's perceptions and experiences of leaving high school early: An exploration Journal of Community & Applied Social Psychology 17, 329-346 Peer-reviewed journal article. Quality assessment ++	Qualitative Data was collected using interviews	To explore the perceptions and experiences of the school context held by young people who left school early. Research questions were: What was the experience of school for young people who left school early? How did the school context impact on their wellbeing? How has their decision to leave school early impacted on their wellbeing? Definition/understanding: Mental wellbeing.	N=12, Australia All participants had left school between 6 months and 4 years previously. Two participants had attended private schools while the remaining 10 had attended government funded schools. Children's age ranged from 16-17 years old Mean age was 18 years and SD was 1 year Sample broken down by gender: n=4 males n=8 females No discussion of ethnicity/ socio-economic status.	The young people expressed that the early leaving process encompassed three phases: exclusion from school, transition into the workforce and the 'now' phase. The participants described school as a negative experience, predominantly characterized by explicit and implicit exclusion. The school context did not fulfil their needs for alternate opportunities, power and control. Consequently, the participants developed feelings of inferiority and resentment as a result of this exclusion, which jeopardized their wellbeing within school. All participants expressed feelings of happiness and relief after making the decision to leave school.
Lynch T and Spence D 2007	Qualitative	Research Question was: How do youth experience	N=4, New Zealand	The findings reveal that stress is integral to living with Crohn's disease.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
A qualitative study of youth living with Crohn's disease Gastroenterology Nursing 31 (3) 224-230 Peer-reviewed journal article. Quality assessment ++	Data was collected using face-to-face interviews which were tape-recorded.	living with recently diagnosed Crohn disease? Definition/understanding: Psychological difficulties (anxiety, depression)	All participants were patients of the gastroenterology department, and each had received diagnosis within the previous 18 months. Children's age ranged from 16-21 years old. Sample broken down by gender: n=1 male n=3 females No discussion of ethnicity/Socio-economic status	The combination of symptoms and stress seems to engender anger, depression, and mood swings. Fear is experienced when the symptoms create knowns and unknowns. Further to this, isolation, hospitalisation, and the burden of diagnostic tests, treatments and surgery cause anxiety. The authors conclude that the findings contribute to the "promoting wellness" literature and will inform those who support the increasing number of young people living and coping with a chronic inflammatory bowel disease.
McCaffrey C N 2006 Major stressors and their effect on the wellbeing of children with cancer Journal of Pediatric Nursing 21 (1) 59-66 Peer-reviewed Journal article. Quality assessment +	Qualitative. A combination of focus groups and 1:1 interviews were used to collect the data. Parents and children took part in individual interviews and Health professionals formed three focus groups	To determine the major stressors of children diagnosed with cancer and their effect on the children's physical and psychological wellbeing Definition/understanding: Emotional wellbeing and coping	N=35, Australia Children, n=6 Parents, n=6 Health professionals, n=23 3 children were being treated with chemotherapy and 3 were in remission Children's age ranged from 5-15 years old. Broken down into age groups: n=1, 5 years old n=1, 8 years old n=1, 11 year old n=1, 14 years old n=2, 15 years old	From the children's data 3 major themes emerged from discussions about stressors. These centred on school, home and hospitals. Children reported that it was not only the physiological symptoms which were attached to their illness which affected their emotional wellbeing but also insensitive behaviours from peers and teaching staff had a huge impact too. However, the very small sample size impacts on generalisability to the wider population of children with these conditions. The authors suggest that there is a need to teach these children life skills

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
			No information recorded for gender distribution No discussion of ethnicity/socio-economic status.	to help them cope with the inevitable stressors they will face.
Murray C D, Warm A & Fox J 2005 An internet survey of adolescent self-injurers Australian e-Journal for the Advancement of Mental Health 4(1) 1-9 Peer-reviewed journal article. Quality assessment + 	Mixed methods Online Questionnaire tool with some open ended questions.	To identify salient characteristics of adolescent self-injurers and their self-harming behaviours and to identify the implications of the findings and the internet for advancing preventative approaches to mental health Definition/understanding: Emotional mental health	N=128, Respondents stated they were from: USA, UK, Australia, Canada, Germany, New Zealand, Finland, Ireland, Japan, Belgium and Israel Participants were self selecting and were all active self-harmers from self-harm internet chat rooms Age ranged from 12-19 years old Mean age 16.6 years (SD=1.7) Broken down by gender: n=14, males (10.9%) n=113, female (88.3%) No discussion of ethnicity/socio-economic status.	Findings from this study related to this review were that, a majority of participants stated that they did not often feel attractive to others. The act of self-harm for the majority of respondents took them on a journey from feeling anxious (before harming) to feelings of depression (after they had harmed) Acts of self-harming were in response to: 89.1% difficult family relationships 85.2% emotional abuse 39.1% broken romantic relationship 33.6% bereavement 28.1% physical abuse 27.3% sexual abuse 85.9% other stressful circumstances (e.g. bad day at work or having an argument with a friend) The authors conclude that the use of the internet as a medium to contact and research these groups of people has proven successful.
Riebschleger J 2004	Qualitative	To explore from a 'child's eye	N=22, USA	Children's views were categorised by

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Good days and bad days: the experiences of children of a parent with a psychiatric disability Psychiatric Rehabilitation Journal 28 (1) 25-31 Peer-reviewed journal article. Quality assessment +	11 face to face interviews with children. Either at their family home or in offices of agency staff. 11 children were interviewed in a focus group at their school.	view' of living day to day in a family that included a parent with psychiatric disability Definition/Understanding: Psychiatric conditions	Children did not have any mental health issues but had a parent who suffered from Psychiatric disabilities Children's age ranged from 5-17 years old. Mean age 9.36 years Sample broken down by gender: n=11 males n=11 females Sample ethnicity: n=3 Latino/ Hispanic n=4 African American n=15 Caucasian Most of the parents were in receipt of Medicaid which implies they had limited income.	four themes: Good days, bad days, views of psychiatric disability and perceptions of psychiatric rehabilitation. Most relevant to this review are views of psychiatric disability. Children could not relate their parents' behaviour to their psychiatric condition. For example parents' withdrawn behaviours were perceived by children as having less attention paid to them. Children lived in fear that their parent may be hospitalised and that they would be sent to stay with family or possibly foster care leaving the child in a state of perpetual uncertainty. The authors conclude that the children in this study framed their knowledge of psychiatric illness in the context of how it directly affected *their* own lives and services aimed at these children should acknowledge this and the fears children have about separation from their parents.
Roose G A, and John A M 2003 A focus group investigation into young children's understanding of mental health and their views on	Qualitative Focus group interviews were used in data collection	To solicit children's views about an appropriate service for their age group including location, structure and staffing. To ascertain children's understanding of the concept of mental health.	N=16, UK (England) Children's age ranged from 10-11 years old Gender was mixed however no information about how many girls or boys was recorded.	Four main themes emerged from the findings namely: The continuum of development of difficulties, access to help and support, service development and gender. The participants showed a sophisticated understanding of mental health and many behaviours were

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
appropriate services for their age group Child: Care, Health & Development 29 (6), 545-550 Peer-reviewed journal article. Quality assessment + +		Definition/understanding: Mental health problems	No discussion of ethnicity/ socio-economic status.	considered to be indication of a serious problem. For example, not being able to put unhappiness aside, inability to concentrate on schoolwork, unusual behaviour such as a lot of crying from someone who doesn't usually cry and lying to cover up sadness. They also thought that school-based services would not be appropriate for their age group. The authors conclude that 10-11 year olds' level of understanding and interest about the concept of mental health qualifies them for a place in discussions about services for their age group.
Ryan-Wenger A N, Sharrer W V, Campbell K K 2005 Changes in children's stressors over the past 30 years Pediatric Nursing 31 (4) 282-291 Peer-reviewed journal article. Quality assessment ++	Mixed methods Study 1: Group discussions were used to collect data from the 2nd and 3rd grade children while data from 4th, 5th, and 6th graders was collected using a questionnaire. Study2: Children in grades 3 through 8 were given a questionnaire to measure stressors and the School-agers'	To compare the items in existing instruments developed between 1972 and 1997 to measure children's stressors (i.e., life events, worries and fears) with the stressors reported by children in the year 2000. To analyse the changes in children's stressors over the past 30 years. To determine the need for development of a new instrument to measure stressors in children.	Study 1: N=194, USA Study 2: N=494, USA In study 1 children's age ranged from 7-12 years. In study 2 age range is not given but participants were from four elementary and two middle schools. Sample broken down by gender: Study 1 Mixed: Males (n=95) Females (n=99) Study 2 Mixed: Males (30%) Females (70%)	The children named 908 stressors that were inductively sorted into 54 mutually exclusive categories of stressors. Only 24% to 50% of the categories were represented in existing instruments. Stressors that emerged in 2000 included being alone, tests, family fighting, too many things to do and boyfriend/girlfriend issues. The authors concluded that their findings support the need for a new instrument that captures the full range of stressors that children experience today.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
	Coping Strategies Inventory to measure coping behaviour, followed by an open-ended question: "What is the worst thing that has happened to you lately?"	Definition/understanding: Young people's coping	In terms of ethnicity: Study 1: The sample included, 83% White, 10% Black, 1% Hispanic and 6% others. Study 2: The ethnic distribution of the six schools was, 93.5% White, 3.5% Hispanic, 3.4% Asian, 1.5% Native American and 0.6% Black. No information about social class recorded Study 1 participants were from rural (n=49, 25.3%), inner city (n=77, 39.7%), and parochial (n=68, 35.1%) schools in a moderate-sized Appalachian county.	
Secker J, Armstrong C, Hill M 1999 Young people's understanding of mental illness Health Education Research 14 (6) 729-739 Peer-reviewed journal article. Quality assessment ++	Qualitative Data was collected using focus group discussions and individual semi-structured interviews. The interview involved use of five vignettes three of which were written by a psychiatrist and the other two taken from another study carried out at the University of Glasgow.	To explore the young people's views about mental illness with particular emphasis on the ways in which they arrived at their understanding of mental illness and on the implications for their responses to people experiencing mental distress. Definition/understanding: Mental health problems.	N=120, UK (Scotland) Focus group discussions, n=102 (17 groups each with 6 participants) Individual interviews, n=18 Participants were drawn from four Scottish high schools: One inner city school serving an area with high levels of deprivation; two suburban schools, both serving relatively affluent areas; and one rural school serving a mixed population. No information about age of participants recorded	By drawing on their personal experience, or on the experience of salient others, the young people made judgements about what was 'normal' behaviour and what was not. There was little difference, either across the four participating schools or between girls and boys about what was regarded as 'normal' although it was clear that for young people from the inner city school depression was a particularly common fact of life. Behaviour which could not be classed as 'normal' or as an extension of normality, and was therefore inexplicable was constructed as

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
			In terms of gender, the sample was mixed with girls almost twice as many as boys. No discussion of ethnicity. No specific information about socio-economic status recorded.	'abnormal' and labelled as mental illness. Media messages about mental illness provided a substitute for personal experience on which they young people could draw to legitimate their judgements. The authors concluded that there is need both to provide opportunities for individual learning about mental illness in ways which take young people's own perspectives into account and to work towards creating a cultural environment which supports the development of more positive attitudes.
Shelton D 2004 Experiences of detained young offenders in need of mental health care Journal of Nursing Scholarship 36 (2) 129-133 Peer-reviewed journal article Quality assessment + 	Qualitative Focus groups were used to collected data. Kleinman's explanatory model interview guide which allows for the expression of the cognitive representation and emotion associated with the illness event, provided the technique used in the study	To explore the experiences of young people detained in the juvenile system and in need of mental health services Definition/understanding: Mental health problems	N=30, USA Participants were minority young people receiving mental health services through a juvenile justice system. All 30 participants had been diagnosed with more than one mental disorder. These included: Substance abuse (60%), depression (37%), bipolar disorder (13%), attention deficit hyper-activity disorder (20%), antisocial behaviour disorder (3%), and conduct disorder (27%)	Five themes became evident in the groups: a desire for caring and stable families, lack of personal control, a love-hate relationship with school, feeling depressed and hopeless, and "it's better to be tough than sick" The participants described reliance on peer groups (gangs) as a method of protecting themselves and creating a sense of belonging when families were not meeting their needs. They expressed anxiety and sadness in the lack of caring, safety and control provided to them. The authors concluded that their

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
			Participants ranged from 13-17 years old Sample broken down by gender: n=10 females n= 20 males All were African Americans	findings indicate the need for multimodal treatment interventions to sequentially address the multiple internal and external factors contributing to persistent problem behaviours in children.
Sin J, Moone N, Harris P 2008 Siblings of individuals with first-episode psychosis. Understanding their experiences and needs Journal of Psychosocial Nursing 46 (6), 33-40 Peer-reviewed journal article. Quality assessment ++	Qualitative Data was collected using inductive semi-structured interviews, guided by a questionnaire developed and piloted locally, with open questions to elicit the siblings' experiences and needs.	To explore the experiences and needs of siblings (aged 16 to 35) whose brother or sister has a first-episode psychosis within a community-based setting in South East England. Definition/understanding: Mental Health problems	N=10, UK (England) Participants were siblings of individual diagnosed with first-episode psychosis Participants' age ranged from 16-35 years old Mean age was 22.8 years Sample broken down by gender: n=2, males n=8, females Sample broken down by ethnicity: White, British, n=7 Asian, Pakistani, n=1 Black, African, n=1 Mixed race, n=1 In terms of socio-economic status: Participants in full-time employment, n=5 Participants in full-time education, n=4 Housewife, n=1	The key findings were grouped in regard to emotional impact, relationships in the family, and siblings' roles and coping patterns. All participating siblings described feelings of being overwhelmed by the psychological impact of the brother's or sister's onset of psychosis and subsequent impact on their own lives and emotional wellbeing. Emotional responses identified ranged from resentment and blame to guilt, loss and embarrassment. The study also revealed that families are able to identify positive gains out of a fundamentally negative experience. The authors concluded that their study highlights the importance of siblings in the recovery of a brother or sister with first-episode psychosis.
Sixsmith J, Gabhainn N S, Fleming C,	Qualitative	To illustrate teachers', parents' and children's'	N=37, Ireland	Children considered family as the most important for their wellbeing, this

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
O'Higgins S 2007 Children's', parents' and teachers' perceptions of child wellbeing Health Education 107 (6) 511-523 Peer-reviewed journal article. Quality assessment ++	Data was collected by allowing children to take as many photos as they liked of whatever they wanted. This was after getting them to quietly reflect on what makes them well and keeps them well.	conceptualisations of wellbeing through a participatory method of research using photography. Definition/understanding: Wellbeing	Children, n= 24 (Eight in each phase) Parents, n=7 Teachers, n=6 Children were from four rural school settings with each school outside the boundary of any city or town. The participating schools included: one boys' school, one girls' school and two mixed gender schools. Children ranged from 8-12 years old Gender was mixed but there was no information about the number of boys and girls. No discussion of ethnicity/socio-economic status.	was followed by "animals and pets" and "sports and soccer" with flowers and clock being the least important. Findings show that differences emerged between parents and teachers and children and adults. Children included pets where adults perceived school as being more important in children's wellbeing. This suggests that this approach has enabled children to illuminate their own unique perspective on wellbeing. It also demonstrates that children can express complex understandings of abstract concepts. The authors conclude that there is need to gain children's perspectives rather than relying on adult perceptions of children's perspectives, in order to inform quality service, practice and policy developments.
Stanley N 2007 Young People's and carers' perspectives on the mental health needs of looked-after adolescents Child and Family Social Work 12, 258-267	Mixed Methods Data from the young people was collected using focus groups. Data from carers was collected using a survey questionnaire with closed questions.	To elicit young people's views to discover what aspects of the looked-after experience they considered might contribute to mental health need and how they thought those needs could best be met To survey the carers and describe which existing services they perceived as	N=332, UK Young people, n=14 Carers, n=318 Looked-after young people were recruited from both residential and foster care settings and included two young women who had moved out of care recently. Young people's age ranged from 12-	Key themes identified from focus groups were: Relationships with mothers and carers Stigma of the looked-after system Choice and control in receiving professional support Involving care leavers in the delivery of services Young people and carers were agreed in highlighting the damaging

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Peer-reviewed journal article. Quality assessment +		effective and what service developments might be relevant to meeting the mental health needs of looked after young people. Definition/understanding: Mental health problems	19 years old Gender was mixed but there was no mention of how many were boys or girls. No discussion of ethnicity/socio-economic status.	effects of the discontinuity and change experienced in the looked-after system. Carers reported high levels of risk behaviour, particularly self –harm, among young people in children's homes. The authors concluded that listening to looked-after young people's views on their mental health needs is instructive and the differing perspectives need to be openly acknowledged and negotiated within care settings in order that relevant and accessible therapeutic and support services can be offered to them.
Vallotton C D 2008 Signs of emotion: what can pre-verbal children "say" about internal states? Infant Mental Health Journal 29 (3) 234-258 Peer-reviewed Journal article. Quality assessment +	Qualitative The children were videotaped. Infants were taped over the course of 8 months and toddlers were taped over 3.5 months. Videographers captured data of spontaneous gestures from the children.	The aims relevant to this review were: • Do infants and toddlers use symbols to communicate emotion-state concepts such as sad, happy and angry? • In what contexts do young children express emotion concepts through gesture? Do they use gestures to communicate their own feelings, or comment on others' feelings? Definition/understanding:	N=22, USA Participants were children who attended a University nursery. Whilst this nursery was open to the general public, priority was given to University staff, students and faculty. Children's age ranged between 4.5-28.4 months old when the study began. 4.5-11.5 months old= Infants (n=10) 17.3-24.8 months old= Toddlers (n=12) Sample broken down by gender: n=3 male infants	Children were able to use gestures to communicate their own feelings and explain what external factors had influenced their feelings. For example communicating a feeling of sadness because they were missing their parents. Likewise the children in this study were able to distinguish the emotions of others and afford reasoning to them. For example noticing that another child is sad and offering the explanation that they are sad because they are tired and need a bottle. The authors conclude that very young

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
		Understanding of own and others' emotions.	n=7 female infants n=7 male toddlers n=5 female toddlers No discussion of ethnicity/socio-economic status.	children are aware of their own and others' feelings and the triggers of these, albeit at a very basic level. Which the authors suggest, is at a much younger age than other research suggests.
van Daalen-Smith C 2008 Living as a chameleon: Girls, Anger, and Mental Health The Journal of School Nursing 24 (3) 116-123 Peer-reviewed journal article. Quality assessment + 	Qualitative Data was collected using participatory focus groups, and face-to-face audio-taped interviews.	To explore and expose the lived experience of anger in the lives of diverse girls and young women aged 14 to 24 years with a particular emphasis on: a) What generates anger for young women b) What their experiences surrounding the expression of anger are c) What their relationship with this emotion is d) How their lived experience of anger affects their mental health Definition/ understanding: Emotional health	N=65, Canada Focus groups (n=9) Participants included the disabled, able bodied, teen mothers, pregnant teens, rural lesbians, heterosexuals and the bisexuals. Participants age ranged from 14- 24 years old They were all female In terms of ethnicity, participants were white, black, south Asian, and Asian. Participants included working class and middle class.	Participants identified the following experiences that caused them to feel anger: being dismissed, devalued, disbelieved, judged and made to never feel good. They further identified sources of anger to be: injustice, gender-based expectations, constantly being judged, not listened to or taken seriously, and made to feel un-important and not good enough. The authors conclude that asking girls and young women to speak about their lives from a position of authority and within a climate of anger affirmation is a mental health-enhancing act in and of itself. Together we can stop the cycle in which girls and young women are taught to be chameleons and free them to become who they are.
Whitehead E 2000 'We should have known better:' exploring the impact of pregnancy on the mental health of	Qualitative (drawing on feminist epistemology) Data was collected using semi-structured interviews comprising a series of questions that	The main aim of the research were to compare and contrast two geographically different areas of the UK with respect to the cultural groups they contain, and to investigate the impact of	N=95, UK (England) East surrey, n=50 (Pregnant group, n=25 Non-pregnant group, n=25) Liverpool, n=45(Pregnant group,	The findings revealed three major concerns in relation to the impact of pregnancy on the mental health of the teenage pregnant women. The first concerns the notion of 'accountability'. Many respondents blamed themselves for their condition which

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
teenage women. Mental Health & Learning Disabilities Care 4(1) 22-25 Peer-reviewed journal article. Quality assessment +	sought to formulate a structure of the young woman's life.	teenage pregnancy on the individuals concerned. Definition/understanding: Psychological wellbeing	n=23 Non-pregnant group, n=22) 48 participants were between 28 and 36 weeks pregnant at the time of the interview. Participants ranged from 16-19 years old All were females Sample broken down by ethnicity: White UK, n=89 Pakistan/India, n=5 African-UK, n=1 Part of the sample was taken from Surrey, a relatively affluent region with a low rate of teenage pregnancy, and the other part was taken from Liverpool, a city with great contrasts of wealth and deprivation and one of the highest rates of teenage pregnancy in the UK	was largely from the moral discourse of the family and friends. The second concerns blame and social consequences, most teenagers considered themselves symbols of disgrace. The third concerned the extent to which the teenager could conceal her condition, initially from her parents and family and later from the wider social network. Through responsibility, blame and social exclusion the teenagers experienced a large amount of mental anguish and, at least until after the birth, a form of 'social death'. The authors concluded that the findings reveal clearly the tensions and contradictions between the various social pressures that form mental stresses for the teenage pregnant women.
Wisdom P J and Green A C 2004 "Being in a Funk": Teens' efforts to understand their depressive experiences Qualitative Health Research 14 (9)	Qualitative Data was collected using In-depth individual and focus group interviews	To describe how adolescents who have been diagnosed with uni-polar depression experience, interpret and understand a condition that has a significant effect on their daily activities, relationships and identify. To address teens' processes of coming to terms with	N=22, USA Focus groups, n=7 Individual interviews, n=15 Three focus group participants had received psychotherapy or antidepressant medication at some time. All individual interview participants	Teens discussed their experiences with depression and getting health care for depression, and described a trajectory similar to that found among adults: a slow growth of distress, a time of being in a funk, and a time of consideration of whether they are depressed. Teens who received a diagnosis from a medical provider then sought to make sense of their depression.

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
1227-1238 Peer-reviewed Journal article. Quality assessment ++		explanations for their experience and how they interpret medical diagnoses. Definition/understanding: Emotional difficulties	had been diagnosed with depression, some were in treatment (antidepressant medication and/or psychotherapy), but most reported no longer engaging in medical treatment. Two were morbidly obese, and 3 reported severe medical issues such as fibromyalgia or a seizure disorder. Children's age ranged from 14-19 years old. Focus group participants (n=7) were 15 years old. Mean age for individual interview participants (n=15) was 16.3 years with SD=1.5 years. Sample broken down by gender: n=9 males n=13 females Ethnicity: Focus group participants were from the urban high school which is heterogeneous, reflecting a range of ethnic and socio economic groups. For the Individual interview participants, 13 were White (non-Hispanic) and 2 were of Hispanic origin. No specific information recorded about socio-economic status	Teens understood a depression diagnosis as a helpful label, a chronic medical problem, or a significant part of their identity. The authors conclude that understanding the subjective experience of adolescents who are depressed might increase health care providers' empathy and improve their communication with teens.
Woodgate L R 2005 A different way of	Qualitative Multiple data collection	To understand the impact that cancer and its symptoms has on adolescents' sense of	N = 15, Canada 12 adolescents were diagnosed with	Three major theoretical categories related to children's perceptions of their sense of self emerged, and

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
being. Adolescents' experience with cancer Cancer Nursing 28 (1), 8-15 Peer-reviewed journal article. Quality assessment +	methods were used and these included: Audio taped, open-ended interviews Focus group interviews Moderate participant observation	self Definition/understanding: Psychosocial wellbeing and coping	either leukaemia or lymphoma and the other 3 with a solid tumour. All participants received chemotherapy. 4 adolescents had undergone radiation, 6 had surgery, and 1 had a bone marrow transplant. Two had a history of relapse and all remained in remission at the completion of the study. Children's age ranged from 12-18 years old. Mean age was 14 years. Sample broken down by gender: Male (n=8) Female (n=7) (Focus groups had males and females alone) All but one were Caucasian No discussion of the socio-economic status	these are: Ways of being in the world I am still pretty much the same person, well almost Respond to me like I am the same person, but treat me special at times. Adolescents experienced changes in their lived bodies because of the symptoms and this in turn impacted their sense of self and way of being in the world. Six ways of being in the world were identified: life as a klutz; life as a prisoner; life as an invalid; life as an alien life as a zombie; and life as a kid. The authors conclude that cancer along with its treatment often has a monumental effect on the adolescents' sense of self. In helping adolescents deal with the changes, it was important to family and friends to respond to them like they were the same person, but also to treat them special at times.
Woodgate L R 2006 Living in the shadow of fear: adolescents' lived experience of depression Journal of Advanced Nursing 56 (3) 261-269	Qualitative Data was collected using audio-taped open-ended interviews and focus group discussions.	To gain an understanding of what it was like to be an adolescent living with depression Definition/understanding: Emotional problems	N=14, Canada All participants had been diagnosed with depression for at least 18 months prior to the study and were all in treatment (e.g. antidepressants, psychotherapy). Six reported a history of depression for 3 years or longer and twelve adolescents reported having some other mental	'Living in the shadow of fear' emerged as the essence of the adolescents' experiences and ultimately defined what it was like to live with depression. The shadow of fear was associated not only with fear of a return of the 'bad' feelings related to their depression, but also to fear of not

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Peer-reviewed journal article. Quality assessment ++			health condition and/or learning disability (e.g. attention deficit disorder, substance abuse). Children's age ranged from 13.5-18 years old Mean age was 16 years. Sample broken down by gender: n=3 males n=11 females In terms of ethnicity, majority were Caucasian (n=12) No information on social class recorded.	getting help, not surviving the 'bad' feelings, and fear of having to do all the 'hard work' in overcoming the 'bad' feelings. This essence was supported by four themes: 'containing the shadow of fear', 'keeping the self alive', 'maintaining a sense of belonging in the world' and 'feeling valued as a human being'. The authors conclude that adolescents with depression need adequate resources and support throughout the illness trajectory, including those periods when their depression is under control.

Appendix 6b: Evidence tables – 'grey'

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
Barnardo's 2008 Welcome to the 'Dead Right Now' World Café: The Roadshow of Life, Death and Hope! 'Grey' literature Quality assessment +	Consultation Event Qualitative data was collected using participatory methods. These results were then categorised and analysed.	To find out about young people's views on trauma, bereavement and loss Definition/understanding: Young people's coping and mental wellbeing	UK (Scotland) 10-17 years old Male, n=26 Female, n=43 No information about socio-economic status or ethnicity recorded	The young people were asked to rate their happiness (scale of 1-10) and detail how they coped when their happiness levels were low. Young people acknowledged that their happiness was transient and they coped with these differing levels of happiness through engaging in behaviours, some of which are concerning. For example slamming doors, shouting, stopping eating or harming animals. Interestingly girls mentioned not eating whilst boys mentioned hurting animals.
Girlguiding UK 2007 Girls Shout Out! A UK-wide research report by Girlguiding UK 'Grey' literature Quality assessment +	Mixed methods Younger participants (Rainbows and Brownies) took part in focus days and group sessions to answer questions/ vote in opinion polls whilst older participants (Guides and Senior section) answered questionnaires, with the Senior section able to access this online. Data was analysed	To investigate what girls in guiding think about being young women today. To investigate the opportunities/ challenges they face, their hopes/ fears and how they interact with the world around them. Definition/understanding: Mental wellbeing	UK (England) 5-25 years old Rainbows, 5-7 years old (n=630) Brownies, 7-10 years old (n=992) Guides, 10-14 years old (n=1039) Senior Section, 14-25 years old (n=581) No information about socio-economic status or ethnicity recorded	Girls listed many things which were important to their mental wellbeing including: -Being successful at school, university and work -Being in love -Having good friends -Having fun -Being part of a community -Being wealthy -Playing sports -Feeling attractive

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
	through categorisation and frequencies. This was carried out by an external agency to ensure accuracy.			
Girlguiding UK 2008 Teenage Mental Health: Girls Shout Out! 'Grey' Literature Quality assessment +	Mixed methods Eight focus groups were held for in-depth discussion of the topic area, a weeklong 'emotions diary' and an online poll was conducted on the Girlguiding website Data was analysed through categorisation and frequencies.	To explore girls experience of hard to manage emotions and awareness and understanding of mental health problems Definition/understanding: Mental wellbeing and mental health problems	UK (England) 10-14 years old (Guides) N=54 involved in Focus groups N=>350 involved in online poll No information about socio-economic status or ethnicity recorded	The girls described how their emotions fluctuated between happiness, contentment, anger and anxiety. Happiness went hand in hand with feeling loved, having good friendships, feeling included, having fun and feeling relaxed. Whilst negative emotions were associated with feeling unloved, excluded, left out or ignored. The girls noted how academic pressures caused them to feel anxious and nervous and how boredom led to frustrations. Body image and physical maturation also had a negative impact on feelings of happiness with many referring to the 'size zero' culture in which we now live.
Haydock E-M 2001 No Harm in Listening Penumbra 'Grey' literature Quality assessment ++	Mixed methods Data was collected from 1:1 interviews with young people, focus group sessions and questionnaires Data was analysed through categorisation, frequencies and theme development	To understand and identify why young people self-harm and the background issues which surround the behaviours Definition/understanding: Mental health problems	UK (Scotland) 16-21 years old Male, n=15 Female, n=31 All those involved in the study were self-harmers No information about socio-economic status or ethnicity recorded	Young people who self-harm described the impact external situations have on their emotional health and harming behaviours. Young people communicated the importance of relationships and relationship breakdowns both as causes of harming behaviours but also relationships as preventative factors. The conclusions drawn by the authors relate to service development and provision and are therefore not

Reference details and quality judgement	Study type	Aims of study and definition/understanding of mental health used	Participants: number, location and characteristics	Main findings and conclusions relevant to this review
				relevant to this review
White J 2003 Scottish Needs Assessment Programme Report on Child and Adolescent Mental Health Scottish Development Centre for Mental Health 'Grey' literature Quality assessment ++	Consultation Event Qualitative, discussion groups and interviews were used to collect data. In total seven discussion groups were held with young people and one 1:1 interview. Activities included thought showering, voting on issues and drawing pictures. Data was analysed through categorisation, frequencies and theme development	To seek the views of children, young people and parents on their understanding of health, including emotional and mental health Definition/understanding: Mental health and emotional health	UK (Scotland) 9-24 years old Male, n=39 Female, n=38 It is noted that some participants were recruited from a minority ethnic community organisation. No numbers are given. Some participants were recruited from a psychiatric service. No numbers are given.	Young people in many cases felt that emotional health and mental health were one and the same and used the terms interchangeably. A minority of young people felt that there was a distinct difference between the terms however this difference is not noted specifically in the report. Young people gave comprehensive lists of what made them happy/ unhappy. The items listed changed with age but included amongst other things: *Happy* -Music -Family -Drugs -Money *Unhappy* -Sad songs -Family -Drugs -Lack of money The authors feel that young people have a sophisticated knowledge an understanding of their emotional and mental health and factors which affect it both positively and negatively.